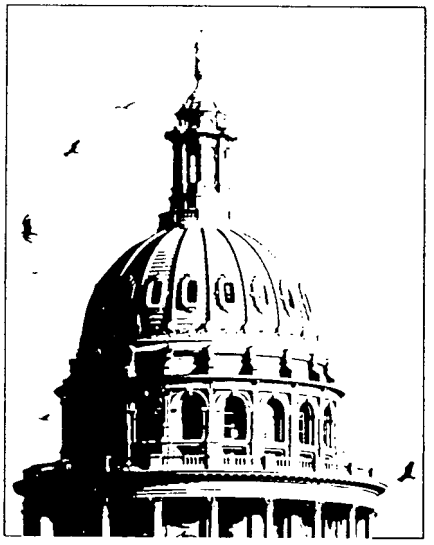
Texas House of Representatives



Interim Report to the 70th Texas Legislature

Committee on Human Services

INTERIM REPORT OF THE

COMMITTEE ON HUMAN SERVICES

TEXAS HOUSE OF REPRESENTATIVES

TO THE SEVENTIETH LEGISLATIVE SESSION

1986

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ERWIN W. BARTON

CHAIRMAN

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September 17, 1986

The Honorable Gib Lewis, Speaker
Members of the House of Representatives
Texas State Capitol
Austin, Texas

Dear Mr. Speaker and Fellow Members:

The Committee on Human Services of the Sixty-ninth Legislature herewith presents its interim report and recommendations for consideration by the Seventieth Legislature.

Respectfully submitted,

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INTERIM CHARGE: To study the Aid to Families with Dependent Children Program (AFDC), including the problems of needy children and their families, the various employment, training and education programs, and other options designed to help Texas families become self-supporting.

Today there are more than one million children in Texas who are living in poverty, and this number is expected to increase in the coming years. The sole income assistance program in Texas for poor children and their families is the AFDC Program, a federal-state partnership which was instituted in Texas in 1941. In these past 45 years, there has been no comprehensive examination by the Texas Legislature of this program, its impact and its adequacy. Nor have the combined primary family support programs--AFDC, Medicaid and Food Stamps--been studied and evaluated as a system by the Legislature. Anecdotal material has been the source of the public's perception for so long that many of us may have begun to lose sight of the fact that sound data are available about Texas' poor. It is this data on which policy decisions for sustaining our vulnerable children and assisting their families to achieve self-sufficiency must be based.

This report attempts to provide such data, along with some analysis and assessment about Texas' situation today and its options for future action. The research presented here reveals both despair and hope--despair at the revelations of our current situation as a state with so many being so poor and having few opportunities to change that circumstance--and hope that such opportunities can be created through a commitment to education, training and employment which leads to real family self-support and out of poverty.

The charge given to this Committee by the Speaker of the House reflects a desire being expressed throughout the nation that programs have as their goal the elimination rather than the perpetuation of poverty among families and that the key for ending poverty is providing the means for families to become self-sufficient. In its initial efforts to understand the needs and define the issues, the Committee held a public hearing on November 19, 1985. Witnesses at the hearing presented many perspectives but shared a common perception: Texas' poor children and their families and the systems trying to address their needs are all in great need of the attention and help of our Legislature. Each person shared special experiences and insights that helped the Committee formulate its research questions. Many of these witnesses followed up their testimony by assisting the Committee in its further investigation of the problems and issues. We thank this group of witnesses as well as the Department of Human Services for its timely responses to our requests for information for this report. All data concerning DHS-administered programs was provided by the Department unless otherwise noted. We also wish to thank Sue Fraser-Frankewicz, M.S.S.W., who did most of the research and writing for this report during a four-month internship with the Committee on Human Services.

I. CHILDHOOD POVERTY IN TEXAS

We begin our exploration of the issues relating to childhood poverty and family dependence by offering some definitions of poverty and how they relate to the AFDC Program in Texas. We examine the relationship between AFDC and poor children in Texas and provide statistical information about those groups. We then look at factors associated with childhood poverty and family dependence and we try to humanize the statistics by offering some vignettes of families who are actually engaged in the day-to-day struggle to survive. Finally, we take a quick look at Texas' progress over the past 15 years in dealing with the problems of poor children and their dependent families.

WHAT IS POVERTY?

What is meant when people talk about the "poverty line" or persons "living in poverty?" The amount of money that society regards as necessary for an individual or family to live at a minimum level of subsistence or at a level consistent with a socially-decent standard of living is usually referred to as the poverty line. For statistical purposes, poverty is defined as a series of income cut-offs or thresholds; at or below such standards, one is said to be "living in poverty."

A set of poverty thresholds computed annually by the Census Bureau is used in the federal government's official count of the lowest income population. The 1986 poverty threshold for a family of four is $11,000 or $917 per month. For a family of three, it is $9,120 or $760 per month total family income. These levels do not automatically determine an individual's or family's eligibility for needs tested programs and they are not used in any way by cash welfare programs. (1) The number of children living in poverty in Texas today, 1,049,923, is based on this standard.

Need Standard

To determine eligibility for its income assistance programs, the State of Texas uses another officially recognized poverty criterion, the Bureau of Labor Statistics (BLS) lower level budget. In administering the AFDC program, states are required by federal law to establish a budgetary need allowance or "Need Standard" which defines in dollars the basic income needs, the state wishes to recognize as appropriate for a family receiving public assistance. In Texas, this requirement is currently met by use of the BLS lower level budget for 1981, updated for changes in the Consumer Price Index and adjusted for the availability of Medicaid and food stamps. Because of this adjustment, the Need Standard is equal to about 76% of the poverty level. Like the poverty level, the Need Standard varies by family size and composition. For FY 86, the Need Standard in Texas is set at $574 per month for a mother and two children, and $691 for a family of four (2).

Payment Standard

States are also required to establish the AFDC payment levels which may be more or less than the actual Need Standard--allowing for consideration of state preferences and funding constraints. The Texas AFDC payment levels

are set at 32 % of the Need Standard or a maximum payment of $184 per month for a family of three and $221 for a family of four. Although Texas ranks 13th among the states in the size of its Need Standard, it is 47th in the level of its Payment Standard or "Recognizable Need." When the value of food stamps is added to the AFDC grant amount, Texas is seen to provide the families of its poorest children with support equivalent to 48% of the poverty level. (3)

Table 1

A COMPARISON OF STANDARDS FOR A FAMILY OF THREE: 1 ADULT/2 CHILDREN

Standard	Annual Amount	Monthly Amount	% of Poverty
Federal Pov. Level	$9,120	$760	100%
TX AFDC Need Standard	6,888	574	75.5%
TX AFDC Payment Standard (32% of Need Standard, also called "recognizable need")	2,208	184	24.2%
TX AFDC Payment Standard plus Food Stamp Value	4,428	369	48.5%

Table 2

FEDERAL POVERTY LEVELS AND AFDC MAXIMUM PAYMENTS IN TEXAS BY FAMILY SIZE

Family Size	Federal Poverty Guidelines		AFDC Grant in Texas	
	Annual	Monthly	Maximum Family Grant	Amt. Family Needs to Reach Poverty Line
1	$5360	$447	$ 75*	$372
2	7240	603	158	445
3	9120	760	184	576
4	11,000	917	221	696
5	12,880	1073	246	827
6	14,760	1230	284	946

* caretaker of SSI Child

Sources: 1986 Poverty Income Guidelines for All States Except Alaska and Hawaii, Federal Register, Vol. 51, No. 28, February 11, 1986, p. 5106.

AFDC Budgetary Allowances as of September 1, 1985, TDHS Income Assistance Handbook, October 1985, p. c110.

AFDC AND CHILDREN'S POVERTY

The Texas AFDC Program is limited and attempts neither to address the needs of all Texas' one million plus children in poverty nor to provide sufficient support to bring those children who do participate in the program above the poverty line. The AFDC Program in Texas is limited categorically to those children who are deprived of parental support. In a small percentage of these cases, this deprivation occurs in two-parent families where one or both parents are disabled, but in most instances, it is due to the absence of one parent. Ninety-five percent of the time, the remaining caretaker parent is female. Fewer than one-half of the children living in poverty in Texas are potentially eligible for AFDC benefits due to lack of parental support.

Of those children who are deprived of parental support, the number that will actually be served is further limited by the size of the grant. Only those children in families with an income below 32% of a lower level budget will be eligible for benefits. The size of the grant controls the number of eligibles since families with income and resources above the level of support are ineligible. If this level is increased, those families just above the previous level would be brought into the program. Of the 469,945 children who are living in poverty and are potentially eligible for AFDC due to lack of parental support, 275,845 are projected to actually receive benefits because of income and resource eligibility. Because of the low level of benefits in Texas, recipients in this state rarely have any income or other resources. Even a half-time job at minimum wage which would produce a gross weekly income of $67 per week would be sufficient to exceed income guidelines for the average-sized AFDC family and result in a disallowance of benefits.

While the focus of this report will remain on the AFDC Program, it should be kept in mind that only 25% of Texas's poor children are touched by the program at all. The remaining 75% are either ineligible or simply unserved. DHS estimates that 60% of those eligible due to lack of parental support are currently served by AFDC.

WHO ARE TEXAS' POOREST CHILDREN AND FAMILIES?

As noted above, the Texas AFDC Program currently assists only those impoverished children who are both very poor and who have been deprived of the support of one or both parents. Of the 21.4% of the State's children living in poverty, fewer than half (9.6% of all Texas children) are also deprived of this support. An even smaller group, 5.6%,or 275,845 children, are actually being assisted this year by the Texas AFDC Program. These children live in 126,000 families; 95% of which are headed by a woman who is either divorced, separated, unmarried, widowed or caring for a disabled spouse.

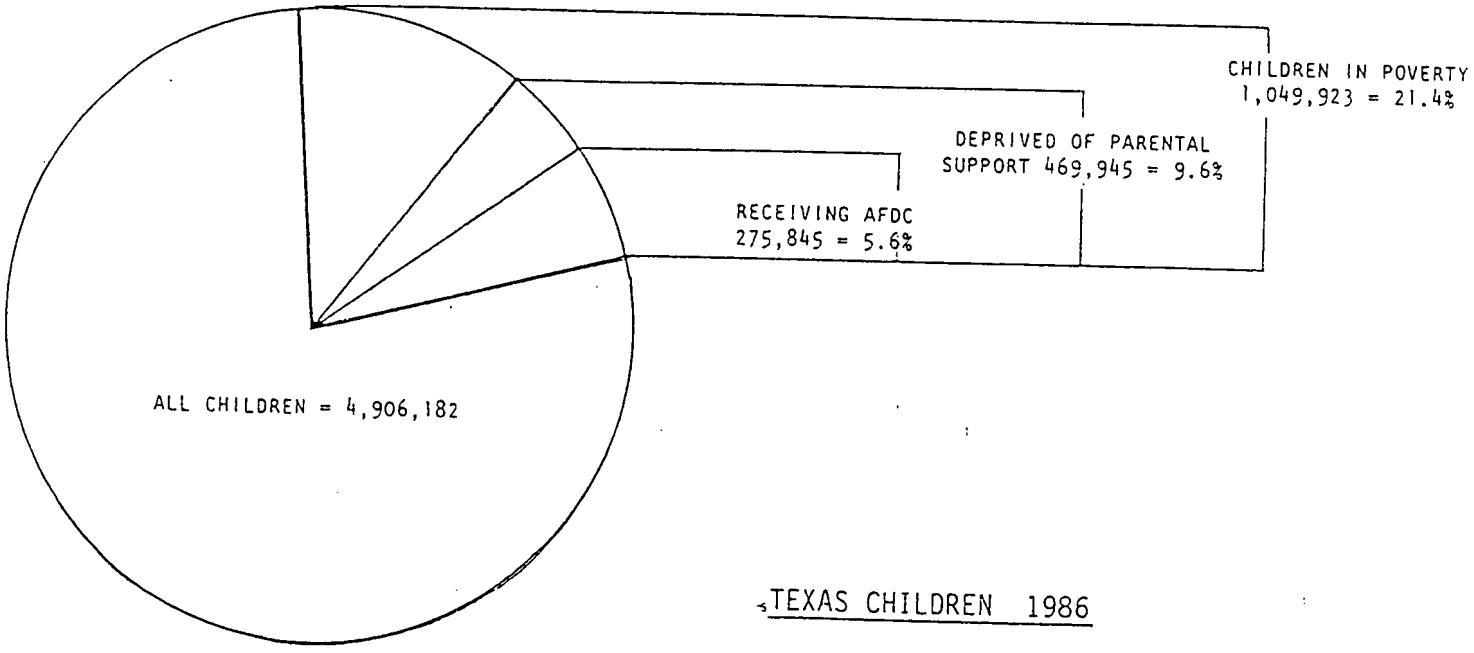
The families of AFDC recipients are generally small, averaging 3.09 persons per family. Overall, 39% of these families have one child, 30% have two and 17% have three. Less than 14% of AFDC families in Texas have four children or more. One-third of the AFDC households include a child under the age of two, and 62% include a child under the age of five. Most AFDC families (70%) are concentrated in four regions of the State: San Antonio,

Dallas-Fort Worth, Houston and the Rio Grande Valley.

AFDC caretakers are female in 95% of cases and have an average age of 29.9 years. Just under 8% are still teenagers themselves; 1.6% are under 18. Three percent are employed some hours each month, but only one-tenth of 1% are employed 30 hours or more. Twenty-nine percent of AFDC caretakers are registered for employment services although less than 18% are required to do so under federal and state rules;70% are exempt from this requirement for one of the following reasons: needed in the home to care for a child under age 6 or an incapacitated family member; the caretaker herself is ill or disabled, or the family resides in an area remote from DHS Employment Services.

Current data is not available on education levels or other indicators of employability of AFDC caretakers. Several sources use 8th grade when referring to the average educational level of this group. The AFDC Income Benefit Survey, conducted by DHS in 1978, revealed that 78% of AFDC caretakers had not completed high school and 49% had from 0-8 years of formal education. The trend seen in 1978 was toward an even lower average level of education, thought to be related to increasing pregnancies and subsequent dropping out of school.

Most families receiving assistance through the Texas AFDC Program (76.9%) have been continuously receiving benefits for less than two years; 57.3% for less than one year. A small number of current AFDC households can be described as long-term dependent cases due to the chronic illness or other disability of the caretaker or other family member.



TEXAS CHILDREN 1986

WHAT FACTORS ARE ASSOCIATED WITH CHILDREN'S POVERTY? HOW DO THE FACTS RELATE TO THE MYTHS?

1) Births out-of-wedlock have reached record numbers in recent years and three-fourths of all children of never-married mothers live in poverty nationwide. (4) Texas ranks fourth among the states in its pregnancy rates for girls between 15 and 19 and first in the nation in births to girls 14 and under. In FY85, 51.8% of all AFDC-assisted children in Texas were dependent because they were born out-of-wedlock. (5)

> Contrary to public belief, AFDC benefits have been found to have virtually no impact on childbearing decisions among young unmarried women. On the contrary, some of states which pay the lowest AFDC benefits have the highest rates of out-of-wedlock births. (6)
>
> "Mothers on AFDC have 1/4 the number of babies while they are on welfare as other women do." (7)

2) An increasing divorce rate has produced larger numbers of families with one-parent (usually the mother) attempting to provide for all the needs of the dependent children. Recent research shows that, nationwide, the standard of living after divorce for women and children drops by an average of 73% while the standard of living for men increases by 42%. (8) More than half of all children eligible for child support received nothing in 1983. And with the earning power of women still much lower than that of men (about 60%), "the lack of child support among a majority of these mother-only families prevents to a large extent their ability to become self-sufficient." (9)

3) Unemployment and under-employment also play a major role in children's poverty. Loss of, or a lack of a job or the reduction in hours or rate of pay can produce poverty quickly in most families. In Texas, 580,000 children (11.8%) are both poor and living in two-parent families. Such families can receive no AFDC benefits in Texas as the state does not participate at this time in the AFDC-Unemployed Parent (AFDC-UP) Program option. In one-parent families, unemployment or under-employment of the sole parent almost surely leads to poverty for the children involved. In these cases, AFDC may be assisting their survival. The 1978 AFDC study found 78% of AFDC caretakers had dropped out before graduating from high school and 70% had no job skills.

The commonly-held belief that the adults who are dependent upon AFDC income support for their families don't want to work is not borne out by the facts:

> Research evidence from training and employment programs suggests that AFDC parents do want to work and will work if they receive the training they need and have the opportunity to secure decent jobs. A decent job need not be a high-paying job. But it certainly is not a job that leaves an AFDC family worse off than it was before because the job pays the minimum wage or less with no prospect for advancement while forcing AFDC parents to sacrifice essential health and child care for their children. (10)

Testimony before the Intergovernmental Relations and Human Resources Subcommittee of the 99th Congress resulted in the report, Opportunities for Self-Sufficiency for Women in Poverty. It states:

> The recent public policy debate focusing on mandatory work programs for AFDC recipients contains an implicit assumption that the problem of dependence lies with the motivation of low-income women. However, the overwhelming evidence presented to the subcomittee clearly indicates that women in poverty desire to be self-sufficient and most desire work as their best means of getting there... (p. 9, emphasis added)

One reflection of the desire of AFDC caretakers to join the work force in Texas can be seen in the figures presented by the Department of Human Services' Employment Services Program for FY85. Of the 62,769 persons registered for ESP, over 41%, or 26,034 were voluntarily enrolled and hoping to become employed. (11)

4) Unemployment among men may be especially pernicious for the future of the family's survival. Direct service providers report that many such men, feeling that they have failed to fulfill their primary role in the family as provider, abandon the family out of shame and/or desperation (since a two-parent family with "able-bodied" parents cannot receive AFDC benefits in Texas, and no other income assistance program exists in the state.)

> Robert Byrd, executive director of the Gulf Coast Legal Foundation, attributed the dramatic increase in his staff's welfare caseload in the last three years to a troubled local economy. Most seeking his agency's free legal services are women.
>
> "There are a stunning number of women who have become the heads of households, taking care of kids alone because their husbands have disappeared after becoming unemployed." (12)

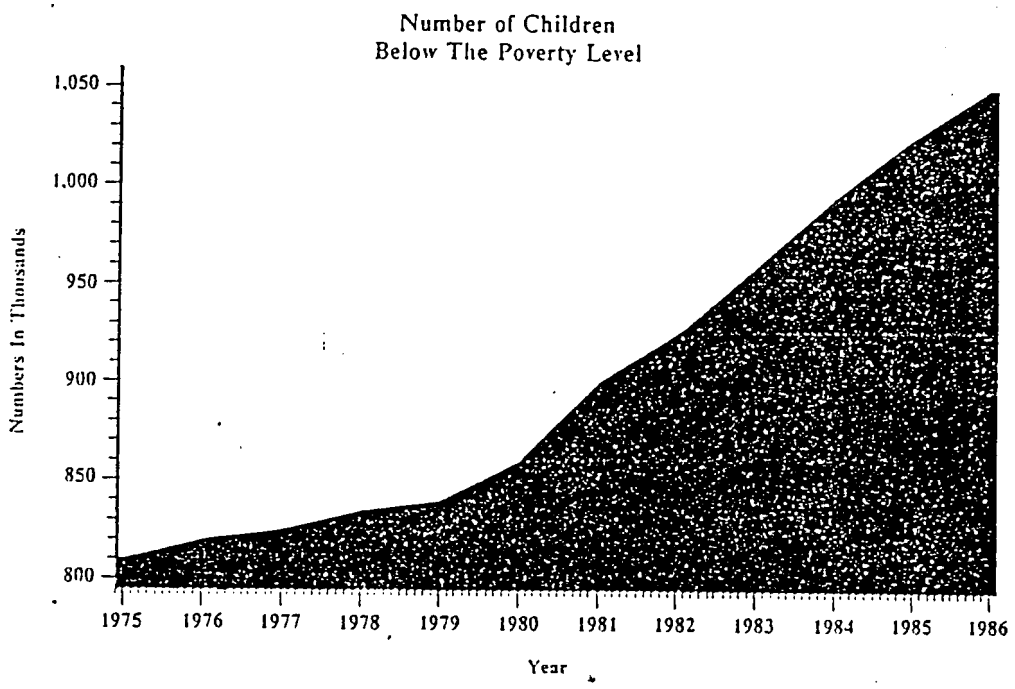
ARE WE GAINING ON THE PROBLEM?

Children living in poverty are a longstanding problem in this nation and in Texas. How has the state fared over the past 15 years in its attempts to alleviate poverty among its children?

Texas' poverty rate for children under age 18 was at a high of 21.7% in 1969. Throughout the 1970's, this proportion became gradually smaller, reaching a low point of 18.7% in 1979. However, the 1980's have seen a steady increase in both the numbers and proportion of poor children. The number of poor children rose from about 850,000 in 1980 to a 1986 figure of 1,050,000. The proportion of Texas children in poverty has likewise risen and has again reached above 21% (21.4%). All ground that may have been gained has been lost.

Further adding to this picture is the fact that the purchasing power of Texas' AFDC grant eroded by 58% in the period 1970-1985. This erosion of

benefits was the most severe among the 50 states in the nation. (13) Clearly, Texas has been losing the battle to alleviate childhood poverty; the size of the gap between what is needed and what has been made available for such needs has grown ever wider.



SOURCE: Texas Department of Human Resources.

II. THE "SYSTEM" OF SERVICES

The economic problems of needy children in Texas are primarily addressed through the major publicly-funded programs designed to assist poor families in meeting their basic survival needs: AFDC, Medicaid, and Food Stamps. Housing assistance, through public housing and rental subsidies, is sometimes available as well. These programs can be loosely described as a system in that they can work together to fulfill some of the basic needs of poor children and families. In many other ways, they are not a true system, having different goals and motivations and different eligibility criteria and administrative rules and structures and lacking the coordination and accountability that make a genuine system. These programs are similar in that none of them is intended to assist the general population; each assists only persons who fall within specified categories defined by financial need.

In part one of this section, we describe each of these major programs, its stated goals, how it works, who is eligible and who is receiving its services. We look also at how each is funded and administered in Texas and how capacity relates to need in each program.

Finally, we examine another group of services to poor families, those specifically intended to enhance or produce self-sufficiency. Administrated by the Texas Department of Human Services' Family Self-Support Branch, these programs include Family Planning, Daycare and Employment Services for income eligible Texas families. We concluded this part with a description of Texas' Child Support Enforcement Program, an essential component in any state system of programs designed to prevent or alleviate childhood poverty.

The second part of Section II attempts to answer two questions:

> "Does this system meet current needs?" and
> "Can this system meet future needs?"

In attempting to evaluate these programs' efforts on behalf of poor children and families throughout Texas, we examine both their adequacy and, to some degree, their effectiveness in meeting state goals. We also look at Texas in relation to the other states as far as its overall effort to aid children who are poor.

Predicting the adequacy of the current system of services to meet future needs involves projecting both future needs and future resources available to address these needs.

AFDC

The Aid to Families with Dependent Children Program originated in the 1935 Social Security Act which provided federal funds spent by a state in aid of needy children and their caretakers. It has been operating in Texas since passage of the Public Welfare Act of 1941. The objective of the AFDC Program is to provide financial assistance and rehabilitative services to needy dependent children and parents or relatives with whom they are living.

1. To help maintain and strengthen family life.

2. To help parents or relatives of children deprived of parental support maximize self support and personal independence in order to continue parental care and protection.

Federal regulations define the basic eligibility requirements of the program but the individual states have important options including benefit levels, income eligibility levels and options for expanded coverage beyond the most basic requirements. Each biennium, through its appropriation to the Texas Department of Human Services which administers the state's AFDC Program, the Texas Legislature makes available the resources that determine grant levels to AFDC children. For each year of the 1986-87 Biennium that amount is approximately $259 million of which $120.5 million will be from state revenues and $139 million federal dollars. The state/federal matching formula (46/54 for Texas) is based, in part, on per capita income in the state. Because Texas' per capita income is relatively high, the State is eligible for a smaller match in the AFDC and Medicaid Programs.

The Texas Constitution places a limit on the amount of state dollars which can be appropriated for AFDC grants. That limit was changed during the 1981 Session from a set dollar amount to a more flexible and somewhat more generous 1% of the total state budget. For the 1986-87 Biennium, that 1% of the state budget is equal to $368 million, or approximately $184 million annually. The current AFDC appropriation represents about 2/3 of this allowable limit. Texas is the only state in the nation with such a Constitutional limitation.

The federal government shares on a 50/50 basis the administrative costs of AFDC in all states. In Texas, the State's Department of Human Services administers the program on a regional basis in 10 DHS Service Regions. Administrative costs for AFDC in Texas, which include salaries for eligibility workers and costs for WELNET, the computer data system, is budgeted at $40.0 million in FY86, of which $20.2 million are state dollars.

ELIGIBILITY

The following eligibility criteria for Texas AFDC Program are set by federal regulation and State law. The notes following each, in parentheses, indicate the source of the criterion.

TO QUALIFY FOR AFDC IN TEXAS, A FAMILY MUST:

1. Contain children under the age of 18 (or through age 18 if in school full time and expected to graduate before 19th birthday) who live with a parent or relative. (Federal rules but data in parentheses represents a state option exercised in Texas).

2. Be residents of the State. (Federal)

3. Be citizens or lawfully-admitted aliens. (Federal)

4. Contain children who are deprived of parental support due to the absence, death or disability of one or both parents. (Federal, but represents our state's decision not to offer AFDC benefits to two-parent families with an unemployed parent)

5. Lack sufficient income or resources to provide for their necessary needs. (Federal, but State defines what are recognizable needs)

6. Agree to register for employment any children age 16-17 who are not attending school full time. (Federal)

7. Agree to assign child support rights on behalf of the children to the State. (Federal)

8. Allow the State to recover medical expenses from other sources, if any. (Federal)

9. Agree for the caretaker of the children to register for employment unless they are exempt due to incapacity or the responsibility for care of a child under the age of six. (Federal, though State has the option to lower age of youngest child to claim as exemption)

10. Not exceed the specified income and resource limits. (States set income and resource limits within federal guidelines.) (1)

Examining those criteria in which state options are involved (numbers 1, 4, 5, 9 and 10) we may note the following:

1. At the present time, Texas has chosen to extend eligibility to 18-year-olds who are full-time students only if they are expected to graduate before age 19. The state receives the federal match for such students. Prior to the 1981 Omnibus Budget Reconciliation Act (OBRA), such a match was available for full-time students up to age 21, and Texas did participate in this option.

   The 19-year cap is described by many as inadequate to ensure that children complete high school or vocational training, as studies have shown that low-income children are less likely to graduate from high school by age 19 than their peers. One out of four 17-year-olds from families living in poverty is enrolled in grade 10 or below, compared with one out of every ten from non-poor families. Five states continue coverage of full-time students at the AFDC level at state expense until age 21 and several others provide more limited cash programs to age 21 under their general assistance programs or other means. (2) This option will be discussed further in Section II of the report.

4. The AFDC-Unemployed Parent (AFDC-UP) Program is available as a state option to families with dependent children who meet the definition of an AFDC family except that two parents are in the home and the principle wage earner is unemployed. Strict and complex eligibility criteria make this program available to only the most needy unemployed families but fills a proven need. This option will be considered in more detail in Section III.

5. By setting its own Need Standard, each state defines the value of the basic needs of poor families. Yet the state is not required to set its grant levels to meet the actual need. Through a budgetary process which reflects what a state wishes to allocate to the relief of poverty rather than the actual need that exists, the states define "recognizable needs" of their poorest families. This then becomes the payment level and the eligibility standard. As noted earlier, Texas has chosen to recognize only a fraction of the Need Standard it has set; e.g., for a family of three, Texas acknowledges the need for a minimum monthly income of $574 (presupposing the availability of food stamps and Medicaid) but chooses to recognize but $184, or 32% of that need. Texas has historically been at the very lowest ranks nationwide in its AFDC grant. It moved up slightly from 49th to 47th place after the 1986-87 grant levels were set in the 69th Session. This occurs in the 21st most wealthy state based on per-capita income. (3) Put another way, Texas, with 99% of the U. S. average per capita income pays 50% of the average (mean) AFDC grant to

its poorest families.

6. The Department of Human Services is currently studying the implications of changing the exemption from employment registration to include caretakers of children under age three only. This option, intended to encourage younger mothers to enter or re-enter the job market before patterns of dependency are established, would almost triple the number of mandatory registrants in the Employment Services Program, already under-funded and under-effective.

7. Section IIH on pages 3-4 of Appendix 2 (AFDC Characteristics) and Number 5 above elaborate on this. Essentially, a family needs to be almost completely devoid of both income and assets to be eligible for AFDC support.

A potential AFDC client must initiate the application process either by mail, telephone or a visit to the income assistance office. She (he) will be mailed or handed an application packet containing a 10-page application form plus Parent Profile Questionnaires for providing data on the absent parent(s). These forms must be completed, returned and received prior to the client's eligibility interview (1½ to 2 hours). When the interview is complete, a total of 14 different forms will have been filled out in even the simplest of cases. There are 15 other forms relating only to AFDC eligibility requirements or case actions. Some of the difficulties encountered in the interview include perhaps a language barrier, illiteracy, necessary and specific documents which the applicant will be asked to locate and to make another appointment bringing those specific documents with them on another day, thereby delaying the entire process and the time frame for the client if elibigility is eventually determined. If and when a family is determined to be eligible for AFDC benefits, the client is advised as to what benefits she/he can expect to receive based on family size and composition and need. All data on the case is entered into and stored in the statewide computer system and a warrant(check) is generated each month that the family remains eligible. Re-determination of eligibility must occur every six months and sooner in some cases. In most cases Food Stamp eligibility will be determined at the same time as AFDC. Texas has adapted its forms to facilitate this dual eligibility function as much as possible.

In FY86, an estimated 126,000 families per month will receive AFDC benefits. These families included 282,978 children in January of 1986 and represent approximately 60% of the estimated 204,000 families below the poverty line who have children deprived of parental support in Texas. There are about 470,000 impoverished children in all potentially AFDC eligible families in the state.

While children being assisted through AFDC represent only 60% of those potentially eligible, they represent less than 26% of all Texas children currently living below the poverty level. Nationwide, 55% of impoverished children are covered by AFDC benefits. Texas' proportion of assisted children is less than half the national average.

The average Texas AFDC-assisted family has 3.09 members and receives $178 per month in cash beneifts. The maximum grant is $184 for a family of three or $221 for a family of four. This grant is intended to cover the family's

expenses for housing, utilities, clothing, transportation, telephone, laundry and cleaning supplies, school supplies, household equipment, non-prescription drugs and remedies and a portion of the family's nutritional needs.

Fraud and Quality Control

According to a 1976 study of both national and Texas AFDC programs done for the University of Texas at Austin's Center for Social Work Research, Texas has one of the most effective fraud investigation units in the country.(4) The Fraud Investigation Division was created in November of 1974. Actual documented fraud among AFDC clients was two-thirds of one percent (.0067) in FY 85 and involved about four-fifths of one percent (.0082) of total AFDC funds, according to the Office of the Inspector General at the Department of Human Services.

Through a regular annual review of a statistically-reliable statewide sample of active AFDC cases, DHS establishes and verifies the facts in AFDC cases as to eligibility requirements and payment levels. This Quality Control Program acts as a double check on casework decisions; it is designed to guarantee that the number of ineligible persons receiving benefits and the number of persons receiving over-payments is kept to a minimum. The maximum acceptable level of error has been set by the federal government at 3%. (This relates to a fraud and error rate of 25% of U. S. Tax Returns, according to the IRS.) Comparatively, the acceptable error rate for AFDC is extremely low.) (5) Restitution for overpayments is made through automatic withholding of 10% of a recipient's grant each month until total restitution has been made. When the overpayment was due to administrative error rather than actual fraud by the recipient, one can imagine how painful this might be. This is another reason the Department strives to keep error rates as low as possible.However, with the enormous caseloads that eligibility workers are now responsible for, this accuracy becomes a severe challenge for the Department.

Medicaid

The Medicaid Program originated in 1965 and was an important component in Lyndon B. Johnson's War on Poverty. The goal of the Medicaid Program is to provide medical assistance for low income persons who are aged, blind or members of families with dependent children.

Within federal guidelines, each state designs and administers its own program and receives a federal match for each dollar spent, representing anywhere from 50 to 83% of the costs incurred. In Texas, that match currently is 53.56%.

Medicaid is a vendor program by law, meaning that all payments can be made only to the providers of services;no payments are made directly to recipients. Benefits include hospital and professional costs such an in-patient and outpatient hospital services, physician's services, lab and x-ray costs; family planning and prescription drug costs as well as routine health examinations and dental treatments for children under the Early and Periodic Screening, Detection and Treatment (EPSDT) program component.

The cost per program participant is currently $53.67 for the monthly medicaid premium plus $4.57, the average cost for prescription drugs per client

each month, for a total of $58.24. Total Medicaid payments in FY85 were equal to $1.4 billion, but of that figure, 12.9% or $182 million was paid for medical services for children. At the 46% matching rate, Texas' share of total Medicaid payments for children amounted to $83.8 million in FY85 and is estimated to be about $94.9 million in 1986.

Poor children and their caretakers are automatically eligible for Medicaid if they are AFDC eligible. Beyond this group of automatic recipients, Texas provides Medicaid coverage to two other groups of persons at medical risk. The first group includes:

1. Children living in two-parent families who are so poor as to be financially eligible for AFDC yet the presence of the second parent renders them "ineligible in Texas. These children are sometimes referred to as 'Ribicoff Children.' "

2. Pregnant women, both married and unmarried, who do not have an AFDC eligible child living with them, but who themselves meet AFDC income and resource criteria.

3. Newborn children born to mothers who are eligible for and receiving Medicaid at the time of the children's birth.

This group is covered by the Children and Pregnant Women Program, organized in response to the 1984 (federal) Deficit Reduction Act which mandated coverage for certain children and pregnant women.

The second group is served by Texas' new Medically-Needy Program which became effective in 1985 after passage of the Indigent Health Care Bill. It includes poor pregnant women, children in two-parent families, and children deprived of parental support and their caretakers--all of whom are ineligible for AFDC due to income. The resource-assets limit is the same in this program as in AFDC ($1000 per family) but families can meet the income-eligibility requirement in either of two ways:

1. Net income does not exceed an income standard equal to 133 -1/3% of AFDC recognizable need standard (or $245 /month for a family of three).

2. The family's income exceeds the 133-1/3% standard, but the family has incurred medical expenses that can be used to "spend down" to the Medically-Needy income standard.

Passage of the Indigent Health Care Bill has extended medical benefit eligibility to all children (and some adults) living at or below 30% of the poverty line, up from 25% of poverty before the bill's passage.

The total number of Texas children served by all Medicaid programs was 334,000 in FY 85. This represents 70% of the 475,000 believed to be eligible under Texas criteria. It represents less than 32% of Texas children living in poverty. Texas ranks 40th in the nation in Medicaid benefits paid and only two states reach a smaller percentage of their below-poverty residents.

Food Stamps

The Foodstamp Program was enacted in 1964 to alleviate hunger and malnutrition in low income households and to replace a surplus food distribution program set up to support farm prices. The goals of the Foodstamp Program are:

1. To strengthen the agricultural economy
2. To help achieve a fuller and more effective use of food abundances
3. To provide for improved levels of nutrition among low income households

The actual value of food stamps issued in Texas in FY 85 was $697,200,000 --all of which is federally financed. Administrative costs are shared on a 50/50 basis by the state and federal governments.

Food stamp eligibility is based on income and assets and is often determined at the same time as AFDC eligibility. However, many more individuals and families are eligible for food stamps than for AFDC; only 23% of Foodstamp households also receive AFDC grants. IN FY85, 1.3 million Texans were served in the Foodstamp Program. Of these, 53% were children, 10% were age 60 or over, 19% were either disabled or providing child care and 18% were adults either employed or seeking employment. The average Texas food stamp allotment per household is $145 per month.

The Federal rules for the Foodstamp Program require aggressive outreach efforts to alert those who may be eligibile for this program. Eligibility workers may go to other sites such as neighborhood or community centers to evaluat and certify potential clients. Yet, although almost all children living in poverty are eligible for this benefit, only 63% of Texas children living in poverty receive meals prepared from food stamp purchases.

Eligibility and certification policy is established by the U. S. Department of Agriculture. Requirements include that:

1. Applicants apply in the county in which they reside
2. Applicants be US citizens or legally-admitted for permanent residence
3. All unemployed able-bodied persons between 18 and 60 must register for employment with their local TEC office prior to determination for eligibility and job offers cannot be refused. Exemptions are granted to mothers with children at home.

Maximum allowable assets for food stamp recipient families may not exceed $2000, and gross income may not exceed 130% of the federal poverty guideline. Net income is the criterion used for households containing someone age 60 or above, and such income may not exceed 100% of the poverty level. Gross monthly income for a family of three must fall below $959 for food stamps to be available; for a family of four, that limit is $1,154 per month before taxes or other deductions.

When a household has been determined to be eligible for food stamps, the family will receive an Authorization to Participate (ATP) card in the mail each month which will be cashed in at a post office to receive the actual food stamps. In some rural areas, direct mail issuance of food stamps is authorized. Eligibility must be re-determined every twelve months--or sooner for some households with earned income. In Texas, 32% of Foodstamp households have some earned income.

Benefit levels are uniform throughout the nation. Foodstamp allotments represent 70% of the estimated cost of the Thrifty Food Plan, the minimum amount of food a family of each size needs to maintain an adequate diet. It is assumed that the family will contribute from its own resources the remaining 30% of the actual cost of food. The AFDC family of three with no other income receives a cash grant of $184 per month in Texas and $185 per month in food stamps. To purchase a minimally adequate diet, this family must utilize $116.50 of its $185 grant for food purchases, leaving $67.50 for all other needs, including housing, utilities, clothing for growing children, laundry and household supplies, transportation, etc.

CHILD SUPPORT ENFORCEMENT

Child Support is another important component in a system to prevent or alleviate poverty among children. It is a primary strategy, requiring absent parents to support their children. Public interest and support in child support enforcement have increased greatly in recent years and such support has been particularly strong when the alternative is public dependence. In 1984, amendments to Title IV-D of the Social Security Act were passed which establishes the current guidelines for state programs of child support enforcement and sets up funding formulas for the financing of such efforts. In Texas, stronger support for enforcement has resulted in transferring the program from the Department of Human Services to the Office of the Attorney General and by passage of support tools such as garnishment of wages, intercept of Income Tax Refunds, state warrant offset such as withholding of portions of income from unemployment checks or any state employed person who is delinquent in their child support.

The Child Support Enforcement Program is directly tied to the state's AFDC Program as all AFDC recipients are required to assign to the state their child support rights as a condition of eligibility. The state then pursues child support payments from the absent parent, including determining paternity when necessary, utilizing also the Parent Locator Service (PLS --a nationwide tracking system which searches for the absent parent through various means including that of social security numbers) and other measures enacted in both state and federal legislation. Another source used by the Attorney General's Office of Child Support is that of URESA, a reciprocal agreement used by all states to exchange such information and enforcement of child support to absent parents who live in states other than Texas. With the exception of the first $50 per month which the family may keep for one child--even though there may be other children in the same family with different fathers, only the first $50 is exempted, all collections are used to reimburse the state and federal governments for the cost of the enforcement effort and for the cost of AFDC payments. If child support exceeds the state AFDC grant, clients lose AFDC benefits and are dependent upon the child support.

The total state appropriation for child support enforcement in Texas for FY86 is $16.8 million (Items 10.b., c. and d. of the Attorney General's Office appropriation). Seventy percent of those administrative costs are paid for through Title IV-D federal grant funds. Although the states are required to finance the 30% match with state dollars, we use child support collections to do this. Child support collections can be considered--and are considered--as general revenue. The result is that this in effect pays back to the state money given to AFDC recipients. Child support enforcement effort is actually self-supporting, using collections to finance 30% of administrative costs to match the 70% fund contribution.

In FY86, the first ten million dollars collected in child support will be used by the Attorney General's Office for their match. Because of consideration of the start-up costs and cash flow, resulting from a changeover of Departments responsible for child support collections, this ten million dollars will cover the expenses for both FY86 and FY87. The next $3.2 million dollars in excess of the $10 million is appropriated to the Department of Human Services in FY86 to be used to offset state dollars used in the AFDC Program. In FY87, $12.8 million can be used by DHS for AFDC since the AG's costs were already taken out in FY86.

Rider 53 to the DHS budget authorizes DHS in FY87 to spend child support collections in excess of the $12.8 million assigned to cover AFDC costs on increased funding for children's services up to an additional $5.5 million. Although the rider does not specify the exact use, discussion was concerned with the child protective services program. Child support collections in excess of the $12.8 million and the $5.5 million are appropriated by Rider 48 to DHS for services to children, but these funds may only replace General Revenue.

SUPPORT SERVICES

A range of supportive services to low income families are provided by the Texas Department of Human Services' Family Self Support Division. The agency states the overall goals of the FSS programs to be:

1. To increase family self-sufficiency, and

2. To prevent future need.

Among the programs' objectives are listed:

1. To promote family health and prevent unwanted pregnancy.

2. To provide daycare to children needing protection; to children of clients seeking employment and clients eligible for daycare services based on household income.

3. To provide quality employment services to AFDC and Food stamp recipients.

These objectives are carried out by three programmatic areas:

Family Planning, Child Daycare and Employment Services.

Family Planning

Access to family planning services is essential to low income families who wish to maintain or regain their self-sufficiency. Unplanned pregnancy can be the proverbial "straw" when struggling with limited resources. It is also the primary factor that leads young mothers into poverty, especially if they are unmarried and unemployed.

For each year of the current biennium, $26.5 million has been appropriated for family planning services through TDHS. This funding includes almost $10 million in Medicaid (Title XIX) funds and over $16 million in Social Services Block Grant (Title XIX) funds and over $16 million in Social Services Block Grant (Title XX) dollars. Generally, the Title XIX funds are available to Medicaid clients which include current AFDC recipients. These Medicaid dollars earn a 90% federal match or $9 for each state dollar spent on family planning. In 1985, 47,971 persons received family planning services under Title XIX. Title XX funds are entirely federal dollars and have considerably greater flexibility as to which clients they may serve. In 1985, 193,760 persons received Title XX family planning services throughout Texas. In 1984, services were expanded to target teenage women at risk of unintended pregnancy in larger metropolitan areas of the state.

These two programs utilize about 70% of state and federal funds for family planning in Texas. The remaining 30% is administered by the Texas Department of Health through the Maternal and Child Health Block Grant (Title V) and Title X of the Public Health Service Act. These two programs in FY86 will provide another $11.5 million in public funding for family planning. TDHS and TDH have a coordinated planning effort for use of the combined $38 million targeted for this service.

Daycare

Daycare is another essential service in assisting families to remain or become economically self-sufficient. Though clearly a necessity for single parent families with young children, it has become more and more important for two-parent families where a second income is vital to the family's survival. Publicly subsidized daycare services in Texas are provided for three groups of children. Listed by priority categories, they are:

1. Child Protective Services referrals.

2. AFDC and SSI recipients whose caretakers are working, looking for work or in training for employment.

3. Foodstamp eligible and income eligible children whose family income is less than 130% of the poverty level for their family size.

In 1985, a total of 38,977 Texas children received some subsidized daycare services funded with a combination of state and federal resources. In all, 14,943 full-time equivalent (FTE) units of service were purchased with $37.8 million. The average daily rate paid to daycare providers was $9.72

per child.

Of the three groups eligible for services, approximately 10% of the FTE units were used for protective services cases (Priority I). Another 63% were utilized by Foodstamp and income eligible children (Priority III). and 27% of all service units were used by AFDC and SSI recipients (Priority II). DHS estimates that for FY85, there were 43,334 children needing services whose parents were participating in DHS employment services and 113,358 children in need of daycare services who were income eligible homes. Of these 156,692 children, 34,429 actually received daycare services in 1985, suggesting that less than 22% of need was fulfilled last year.

In FY 86 and 87, all state funding has been eliminated from Day Care Services in Texas. DHS projects that the $33.9 million in Title XX funds will buy less than 13,000 units of services each year of the current biennium.

Employment Services

In general, employment of the caretaker single parent offers the greatest potential for securing adequate income and for establishing a pattern of self-support that can lead a family from welfare dependency. The goal of assisting AFDC caretakers to join or rejoin the labor force is one that enjoys almost universal consensus.

The Texas Department of Human Services administers a variety of programs aimed at assisting AFDC and foodstamp recipients to obtain employment leading to self-sufficiency. The focus of the employment activities is on full-time, unsubsidized employment. The current service consists of core programs known as:

Work Incentive Demonstration Project (WIN Demo)
AFDC Job Search
Foodstamp Job Search

There are also two experimental programs:

Home Health Aide Project (HHAP) which is funded by the Health Care Financing Administration and state funds, and

Job Training Work Experience Program (JTWE) which is funded by special federal and state allocations.

In addition, two special teen parent projects, one in Houston and one in El Paso, are being funded jointly by DHS, TEA and TDCA.

Sources of income for Texas Employment Services administered by DHS include:

State Funds	$ 6,568,958
Title IV-A (Job Search)	3,196,162
Title IV-C (WIN Demo)	4,245,855
USDA (Foodstamp Job Search)	2,100,000
Special Federal (JTWE)	118,993
Title XX (SSBG)	22,500
Total	$16,252,468 for FY86 (6)

From 1969 to 1981, Employment Services to Texas AFDC recipients were provided through the Work Incentive Program (WIN) and since 1981, through the WIN Demo Program. The program is mandated under Title IV of the Social Security Act which requires that all AFDC recipients, unless specifically exempt, register for employment services. Exempt persons include individuals who are under age 16 or over 65, under 19 and a full-time student, incapacitated or ill, caretakers of a a child under the age of six or an ill or incapacitated family member living in an area remote from program and/or employment opportunities or already employed 30 hours or more per week. (These exemptions also apply to AFDC and Foodstamp Job Search Programs.) In FY85, 82% of AFDC caretakers were exempt for one or more of these reasons. Due to the fact that over 26,000 exempt individuals registered for employment anyway, 30% of caretakers were registered for employment services in 1985.

WIN Demo is funded with 10% state and 90% federal dollars. The state's share in FY86 is $466,000 while Title IV-C funds contribute $4,194,390 of the total $4.66 million program budget.

Currently the WIN Demo Program operates through a contract with the Texas Employment Commission covering 69 counties (previously 84 counties) and through the efforts of DHS staff. The contract provides for automatic referral of mandatory program registrants to TEC for employability assessments and job-placement assistance, while in 35 counties, Family Self-Support Staff are expected to provide similar services. Voluntary employment services registrants are served by FSS staff exclusively. One hundred and fifty counties do not participate in this employment program at all. In FY 85, 5,821 employment entries were obtained through this program.

Job Search requires individuals to seek a job in a structured program, either individually or as a part of a group effort in a "job club." It may provide training in such activities as the use of resumes, interview techniques and how to contact potential employers.

The AFDC Job Search Program, a variation within WIN Demo, is available statewide and uses FSS staff and contracts with public and private agencies to provide individual and group job-seeking and placement assistance to AFDC recipients. Twenty counties have Vendor Job Search contracts with job placement agencies which pay for the placement of clients in unsubsidized full-time (30 hours or more) employment. Estimated FY86 costs are $6.38 million and include $3.19 million to come from federal Title IV-A funds and $3.19 million in state funding. In 1985, 10,146 employment entries were obtained through this program, representing 64% of all AFDC job placements. About 95% of these clients were placed by DHS staff and 5% through vendor contracts.

Foodstamp Job Search is funded with $2.1 million in USDA funds. Services are provided through contracts with TEC to provide job assessment and placement services to Foodstamp clients who do not also receive AFDC grants in 28 counties. In FY85, 397,572 households met this description and 130,497 were required to register for Foodstamp Job Search. In all, 6,036 employment entries were reported in this client group, representing 4.6% of program registrants.

The only employment training programs administered by the Department of Human

Services are the two limited demonstration projects mentioned above: HHAP and JTWE. The Home Health Aide(HHAP) is a demonstration project in which AFDC recipients are trained for employment as home health aides to serve elderly and disabled persons in their homes. The project is authorized under the OBRA of 1982 and funded 90% by the Health Care Financing Administration under the Medicaid Program. The 10% matching dollars come from local and state funds. The project's goals are to:

1. Help AFDC recipients become self-supporting, and

2. Help elderly and disabled persons avoid unnecessary placement in instituions

DHS contracts with the cities of Austin, El Paso, Fort Worth and San Antonio to administer local projects. HHAP began operations in Janury of 1983 and is scheduled to end in June of 1986. As of October 1985, 635 AFDC recipients had been trained and employed as home health aides, according to testimony heard by the Committee in November.

The Job Training and Work Experience Program (JTWE) is a three-year demonstration grant diversion project that was designed to provide job preparation and work experience for AFDC clients that would lead to permanent unsubsidized employment. The program stipulates that the average amount of the client's AFDC grant be diverted to the employer as a subsidy for providing training and oversight while the client receives wages in lieu of the grant. The original JTWE program was authorized by House Bill 1299 in May of 1983 and operated from January 30, 1984 to August of 1985 in Ector and Midland Counties. The bill provided for an all-voluntary job training and work experience program funded entirely be state money (which amounted to about $3,000) in new state dollars in the first program year). From February 1984 to September, 1984, 29 individuals entered the program and six clients entered regular employment (7). This program was phased out in 1985. A parallel effort with similar design that utilizes federal funds and requires that those who choos not to participate in JTWE must participate in other WIN Demo activities has been tried in four other Texas counties. It will be phased out at the end of this fiscal year with no recommendation to continue, according to Joan Reeves' testimony for the Department. The JTWE budget for FY 86 is approximately $400,000.

Other Employment and Training Programs

The Job Training Partnership Act is another employment program which serves the AFDC client group. It is administered in Texas by the Department of Community Affairs and operates under the management of local Private Industry Councils. Although not a part of DHS Employment Services, DHS does have a non-economic agreement with the JTPA program operating in several areas which allows DHS staff to refer clients to appropriate training programs run by JTPA entities in those areas of the state.

Section 203 of the Job Training Partnership Act states:

Recipients of payments made under the program of Aid to Families with Dependent

children under an approved state plan...who are required to have registered...shall be served on an equitable basis, taking into account their proportion of the economically disadvantaged persons 16 years of age or over in the area.

According to the testimony of Clyde McQueen of TDCA's Training and Employment Development Division, 4,227 AFDC clients entered JTPA programs throughout Texas during the 1985 Program year. This group represented about 17% of all JTPA clients for that period. Of the 4,227 involved, 1558 actually entered employement after being in the training programs. This group of successful employment entries represent 13.6% of all JTPA participants who entered the programs that year. Texas receives about 190 million dollars from Washington for JTPA; 70% is allocated for training-related services, 15% for supportive services such as daycare and transportation, and 15% for program administration.

Through the participation of seven state agencies, a unified state-wide initiative to increase the self-sufficiency of teenage parents is being developed. DHS has launched pilot projects (in concert with TEA and TDCA) in El Paso and Houston. At the local level, these projects are co-sponsored by the local JTPA Private Industry Councils and the employment and training components of the pilots are a major element of the service delivery structure. Evaluative data on these two projects, Project Redirection in El Paso and TEAM II in Houston, is not yet available.

HOW WELL DOES THIS SYSTEM MEET CURRENT NEEDS?

Although the efforts of this Committee in responding to the Speaker's interim charge regarding children in poverty were necessarily limited given the complexity of this issue and the resources available, all evidence based on testimony heard by the Committee and research conducted by the Committee staff, indicates that current needs are not being met. The system appears inadequate both in regard to the number of children who are truly in need that it is able to reach and in the level of assistance it does provide for those children in deep poverty who are touched by at least some part of this system. In addition, programs designed to assist families to achieve self-sufficiency are inadequate in the numbers that are reached and in the sustained assistance that is necessary to break the poverty cycle.

Only 26% of Texas' poor children are receiving any cash assistance; about 32% receive Medical benefits and about 63% are assisted by the Foodstamp Program. Since numerous investigations by teams, task forces and special panels and committees have studied and confirmed the efficiency of the income-assistance programs in Texas, given their complexity, one may conclude that problems of inadequate coverage are the result of inadequate resources. Even while Texas enjoyed the fourth highest taxing capacity in the nation (1982), we remained in 49th place in terms of both tax effort and AFDC grant levels. (8) Today, Texas' "recognizable" need standard or maximum AFDC grant per family places it in 47th place among the states.

Horizontal Adequacy

The problem of coverage, or "horizontal adequacy," means, essentially, that if Texas' goal is to assist its poorest children, its efforts are failing far short of the mark. DHS estimates that fewer than 60% of families with children deprived of parental support (all potentially eligible for AFDC assistance) are being served by the AFDC program. One must ask why this is true. Some answers were suggested by direct services providers in state, local and private agencies who testified at the Committee's hearings or were interviewed by Committee staff:

1. Lack of Awareness. The AFDC-Medicaid Program conducts no outreach activities to alert the poor to the availability of assistance when it is needed. Social service providers say many people either do not know about or do not understand the rules relating to their eligibility for their income and medical assistance.

2. Problems of Access. In order to establish and to maintain eligibility for income maintenance services, clients must be interviewed at a DHS office somewhere in their community or county. Such appointments are made at the convenience of the agency staff and may be scheduled as early as 7:30 am and are likely to entail either use of public transportation (if available) or reliance on a friend or neighbor for a ride. Child care arrangements may need to be made, especially if schoolage children must be left in someone's care while mother and pre-schoolers begin the journey at 7:00 am or earlier. Any of these factors can contribute to missing or being late for an appointment, but due to the demands on the eligibility workers, if the client is more than ten (10) minutes late, the appointment is cancelled and the case is denied. In 1985, 42% of all AFDC denials of initial applications were because an appointment was not kept.

3. Documentation. Once the client is at the initial interview, she/he may or may not have all of the documentation required to determine her family's eligibility; the application cannot be approved until or unless the documents are received. Collecting the documents may take another trip or trips using whatever modes of transportation which may be available to the client plus the first-stated other problems. For some, the cost alone of providing this documentation can be a roadblock. A mother with two children will pay $21 in some places to obtain copies of their three birth certificates. Lastly, the eligibility process itself can be intimidating to many since the information required of applicants to document the case covers virtually every aspect of the family's life including areas many would consider strictly personal.

4. Caseloads. The Assistant Commissioner for Income Maintenance Services told the Committee that AFDC/Medicaid eligibility workers are now responsible for caseloads that average 158 families. This represents a 33% increase for each worker since 1982. Direct service staff testified that in some offices, the caseloads per worker had reached 250 families which can include both AFDC and Foodstamp eligibility. While trying to manage this caseload in which each case may require action monthly, or at a minimum, every six months, these front-line

workers were interviewing 2 to 4 new applicants per day in 1½ to 2-hour interviews. The amount of stress (and subsequent burn-out and staff turnover) was described as high, approaching intolerable levels in some offices. Given this situation, it seems likely that the client who requires extensive assistance with her application forms and documentation or who would require a home visit for her eligibility interview will not always receive such help. Stress appears to extend beyond the caseworkers to clerical support systems as well. Committee staff heard reports of the notification of eligibility interviews arriving in the mail a day or two after the date of the scheduled interview and, following certification, another 15-20 days for the family's data to be entered into the computer's data bank and a warrant to be mailed to the new client. The time between initial application and receipt of benefits or notification of denial is, by law, not to exceed 45 days. At current staffing levels, the Department is not always able to meet this criterion.

5. Grant Levels. Probably the largest factor in the state's failure to assist 40% of its poor families with children deprived of parental support is the very low level of the AFDC grant in this state. The caretaker in a three-person family who has a minimum wage job will earn, at best, $6,968 per year and be ineligible for AFDC assistance even with deductions for child care and other work-related expenses and the short-term earned income disregards. But her family will still lack $2,152 needed for family subsistence at the poverty level. It is this group of families in poverty who are likely to make up the bulk of the 40% gap in coverage. We can begin here to appreciate, as well, the absolute inadequacy of minimum wage employment, particularly if there is only one potential wage-earner, to support a family in the United States today.

Vertical Adequacy

The size of the AFDC grant is one indicator of the second type of adequacy problem in Texas, vertical adequacy. Even for those who are covered by the major income assistance programs, the level of support is nowhere near adequate to lift the family out of poverty to meet their basic subsistence needs. As we have noted, Texas' AFDC grant will bring a family of three to 24% of the poverty level. The grant, combined with foodstamps, will lift them to "48% of poverty." How, we ask, can families survive at 48% of the subsistance level?

In an attempt to find answers to this question, Committee staff conducted interviews asking direct service providers in several public and private non-profit community agencies who assist the poor in Austin and Travis County to share their knowledge and experience of this area. There was a consensus among this group that those families who, besides receiving assistance through AFDC/Medicaid and foodstamps, were being assisted with subsidized housing either in public housing or with Section 8 housing subsidies were those best able to survive on their monthly grant. However, this group of families represents only 28-32% of Texas AFDC cases. How are others coping in this crisis situation?

Not very well at all. Some live with other families, "doubling up" to

extend meager resources so that 4 to 6 children may have to share one bedroom. Some live in housing so substandard as to be a serious risk to the safety and/or health of the children. Sometimes there is no running water, sometimes no glass in the windows, much less screens. Some live in tents for part or all of the year. Some move every few months as they fall behind on their rent and utilities payments. Some families survive by utilizing every possible resource they can locate: federal commodity programs, WIC, community food pantries, utility assistance programs, "Christmas baskets," church emergency funds, etc. Others take in ironing, do informal baby-sitting, take in boarders or sell their handiwork to make a few extra dollars.

We asked the front-line professionals how life at the survival level affects the children they see. They all responded that such children are less prepared to enter school: emotionally, intellectually and physically. Frequent moves and broken relationships leave many poor children less emotionally stable than their peers. They are often behind them at school age in both language skills and physical health and are more likely to be at school late due to lack of clothes or shoes or, for the homeless children, lack of an address to be considered a "residence."

Service providers also noted higher levels of abuse and neglect among these children living in poverty. Along with family violence, many have early and continued exposure to violence in their neighborhoods, alcohol abuse and aspects of the "sub-economy" such as prostitution and drugs. Several noted that in situations where the caretaker was working to provide family income, children were literally raising children. The Committee heard testimony from a child development specialist whose agency has recently received reports from school principals about children as young as six and seven years old being kept home from school to care for three and four-year-old siblings while their mothers work to support their families.

Before attempting to evaluate the overall adequacy of this loose system of services, we will examine the adequacy of Texas' Family Self Support programs, those programs that can be used to promote self-sufficiency in poor families. For this we rely on information supplied by the Department of Human Services in response to questions about service needs versus program capacity. These data are based on needs assessments conducted bi-anually by the Department of Human Services and are service data provided by the various program areas.

Family Planning services are a most important component in any effort to help individuals and families maintain their self-sufficiency. They can be instrumental in preventing dependency situations and in facilitating a return to self-support among those who become dependent for some period of time.

The average cost per Family Planning Client in the Title XIX and Title XX programs was $79.67 last year and included health screening and one year of contraceptives. A 1982 Impact Evaluation of TDHS Family Planning Programs revealed that for each $1 spent on Title XIX clients, $4.09 in direct first-year costs was saved in averting unplanned pregnancies. Title XX programs had a 2:1 savings to cost ratio, according to testimony of Peggy Romberg, Executive Director of the Texas Family Planning Association before the Committee.

While DHS Family Planning Services reached over 240,000 individuals in FY85, the best estimate of need for such services exceeds 524,000 persons for that same year. The Department estimates that 169,422 persons may be eligible for Title XIX services and another 355,080 for the Title XX FP program in 1986. Since the Department is able to serve less than 50% of its target population, it is safe to conclude that capacity in its vital family planning programs is less than adequate to realize the desired impact-the prevention of an unintended pregnancy, the largest single cause of welfare dependency in Texas.

Daycare services are another essential element in the state's efforts to help families maintain or regain their self-sufficiency. They are badly underfunded now and in serious jeopardy of receiving further budget cuts. While DHS made efforts to assist almost 63,000 AFDC clients prepare for and enter employment in FY85 (over 26,000 of whom were voluntary registrants and thus are known to have had children under age six), only 4000 FTE places were available in subsidized daycare situations to enable this process. About 15,500 children received at least some daycare services in this part of the program. The Department estimates that during 1985 it could have utilized placements for 43,334 children under age 10 whose parents were participating in DHS employment services programs.

In all categories of subsidized daycare - children in need of protection from child abuse and neglect, children with parents participating in employment services, and children in single parent households with an employed caretaker earning less than 130% of the poverty guideline for that family size - 38,977 children were served in FY85 out of a known need of 158,208. Less than 25% of the known need for subsidized daycare in these highest priority categories (the only ones who receive state and federally subsidized daycare) can be met at current funding levels. As noted above, there are currently no state dollars for daycare in this biennial appropriation, and the $33.9 million in Title XX (SSBG) funds will purchase fewer than 13,000 FTE daycare placements in each year, 1986 and 1987. This appropriation represents less than 75% of the level requested by the Department in its LAR.

Some things that result when daycare needs cannot be adequately met are:

1. Job opportunities are lost.

2. Children left in at-risk situations with older siblings (as young as five or six) providing the child care.

3. Families broken up as children are sent away (sometimes to other cities or states to live with relatives so that the parent may work.

Department staff describe the daycare situation as critical, as they understand the centrality of this vital support service in any efforts to assist families to become self-supporting through employment while maintaining family integrity and some reasonable levels of safety for dependent children.

Employment Services Program

Assessing the effectiveness and adequacy of Texas Employment Services to its AFDC recipients is a discouraging process. Debates have raged about the most effective means to link welfare and employment. It is clear that promoting self-sufficiency among poor women is complex and defies simple solutions.

What stands out in a review of Texas' efforts to date are, first, a lack of resources sufficient to meet objectives and, secondly, a disappointing rate of success in virtually all approaches tried. The link between these two seems inescapable.

A 1985 report to the Legislature notes that during the 13 years of its existence in Texas, geographic coverage of the WIN program was never statewide. Due to its limited funds, WIN was restricted to the large Texas counties and the Rio Grande Valley, providing coverage to about 60% of the AFDC population. Although the federal match for WIN and WIN Demo has been a favorable one--90%--the total amount of federal funds made available nationwide has been inadequate. Another reason Texas has not fared well is that the formula used to determine each state's share of this already small appropriation is based in part on AFDC grant level which is extremely low in this state (9).

With $8.5 million in federal funding and $3.36 million in state dollars in FY85, DHS Employment Services attempted to deliver services to some 62,769 AFDC clients. This group included 36,735 mandatory registrants (59%) and 26,034 persons who volunteered for job assistance services (41%). Just under 85% of this group received any unemployment services in either the WIN Demo or Job Search Programs. About 16,000, or 25%, of program participants entered employment from the program while 18% were still employed after 30 days. This group includes both full and part-time employment entries. Follow-up activities to determine employment status at 90 days are not carried out. However, a carefully-controlled study of WIN Demo and Job Search in Texas in 1984 revealed a 90-day success rate of 3.7% for WIN Demo and 3.5% for the Job Search component. (10) Success was defined as full-time (30 hours or more) job placements lasting 90 days or more and resulting in a reduction (not necessarily elimination) of the AFDC grant. This study reports that the majority of jobs entered were minimum wage jobs in service industries with actual starting wages averaging $3.50 per hour in both programs.

DHS does not routinely record the starting wages of its employee entrants. Those clients who entered employment through TEC contracts with the Department in 1985 were known to have averaged a starting wage of $3.75.

In both the 1985 statistics and the 1984 study cited above, we see a higher success for voluntary employment services participants. Whereas 17% of mandatory registrants entered employment in FY85, over 37% of those in the programs voluntarily entered jobs. In the 1984 study, 3.3% of mandatory registrants in WIN Demo entered and remained in employment while 5.2% of volunteers did so. The difference is even more marked when comparing the Job Search successes from the cited study: 1.9% for mandatory participants and 8.2% for volunteers.

DHS EMPLOYMENT SERVICES, 1985 (WIN Demo and Job Search)

	Mandatory	Voluntary	Total
Number of persons registered	37,735 (59%)	26,034 (41%)	62,769
Numbers of person entering employment (full & part time)	6,300	9,667	15,967
% of registrants entering employment in 1985	17%	37%	25%
% employed at 30 days (retention rate of 71.9%)	Unknown	Unknown	18%

Source: Testimony of Joan Reeves, Asst. Commissioner for Family Self-Support, Texas Department of Human Services at Hearings, 11-19-85.

The Department reports it served about 85% of Employment Services registrants in some way in 1985, about 52,700 persons. Thus, TDHS spent $11.8 million on AFDC employment efforts in FY 85 at a cost of about $224 per person served. Applying the 30-day retention rate (72%) to the 11,592 who were full-time employment entries produces a 13% employment rate at 30 days and a projected 90-day retention of 9-10%, based on the ratios found in the Job Search Field Test. If 10% of program participants were employed at 90 days, DHS Employment Services Programs resulted in the successful employment of 3.2% of all AFDC caretakers in FY85. A lack of evaluative research with control group design leaves us no way of knowing how many of these estimated 5,270 persons would have entered employment during the year even without the help of the programs but it does appear that low-cost employment efforts without training are of scant value to the State and may be accomplishing little more than fulfilling federal AFDC program requirements.

Of the two experimental programs with training components, Job Training and Work Experience (JTWE) and the Home Health Aide Projects (HHAP), JTWE has had virtually no success in its first two years of implementation. Billed as a low-cost employment and training model, it has reaped very low benefits for the time and energy expended. In the voluntary JTWE Program's first 10 months, two persons finished the six-month training-subsidized employment phase. Ultimately, six persons entered unsubsidized employment through JTWE's original employment, but four of these six were considered uncharacteristic of the target population as they were high school graduates (while less than 24% of Texas AFDC caretakers graduated from high school). In addition, 72% of the program participants dropped out before completion. The January, 1985 report, Independent Evaluation of the Texas Job Training and Work Experience (JTWE) Program, conducted under contract with the Texas Department of Community Affairs, concludes that, "It seems reasonable to associate the high program drop-out rate with the barriers to employment faced by many AFDC recipients in Texas, and the inadequate efforts within the JTWE Program Model to overcome them."(11).

The second phase of JTWE and the Home Health Aide Projects are currently

undergoing evaluations but early reports are not encouraging. One problem encountered in the HHAP program was that once participants had completed one month of classroom and eleven months of supervised on-the-job training, there were almost no full-time jobs to accomodate the program graduates. Evidently, most home care agencies can attract sufficient labor to fill their demand for services without offering guaranteed hours nor much more than the minimum wage. An interim evaluation of the program, dated August 1984, showed that most participants in HHAP (66%) had been employed in this field previously while 93% had some history of employment. (12) A final evaluation of HHAP in Texas will be completed this summer.

JTPA programs, which have built-in incentives to produce placements and are thus known to be vulnerable to selection of those most likely to succeed (creaming), placed 37% of their AFDC program entrants in FY85. Of those tracked, 69% were employed at 90 days (13 weeks), suggesting a successful placement rate of 25%. The director of the TDCA Training and Employment Development Division testified at Committee Hearings that, when working with the more typical AFDC client, "Thirteen weeks of training hardly dents an 8th grade education." He also cited lack of sufficient daycare and transportation subsidies and the loss of medical benefits as the biggest obstacles to AFDC clients being able to accept a job that might be offered to them. The dearth of supportive resources undermines the efforts of other components in this loosely coupled "system" designed to end dependency and eliminate poverty for Texas children.

Child Support

While there are clear benefits to the State in the Title IV-D Child Support Enforcement Program, the benefits for the AFDC family are more mixed. The $50 per month "disregard" is a limited benefit. The first $50 collected on behalf of an AFDC-assisted family is forwarded to that family and is disregarded when computing eligibility for AFDC benefits. The $50 is a direct benefit over and above the grant. However, the $50 applies to just one family--if the family has more than one child by more than one father and $50 is collected above the eligibility level for more than one child, only the one $50 amount is disregarded. This income is not disregarded in computing foodstamp benefits and can also result in the loss of foodstamps in the amount of 30¢ for every dollar received in the disregard, somewhat lessening the impact of the support payment. Also since the $50 limit is per family, larger families will have a proportionately smaller benefit than smaller families.

For families that receive adequate and sustained child support through IV-D collection efforts, income concerns may be resolved. Such occurrences are rare. Since federal law requires a dollar-for-dollar reduction in AFDC, benefits end when child support exceeds the cash grant. In Texas, this is a very low amount and often so are the child support payments. Loss of other AFDC benefits, particularly Medicaid, may make a family worse off than before. Additionally, because child support payments are often unreliable, a family may soon find itself reapplying for AFDC but suffering from a gap between interruption of child support payments and resumption of AFDC assistance.

Although both the $50 disregard and the dollar-for-dollar reduction of benefits are part of the federal requirements, the 1984 amendments allow states to receive from the Secretary of Health and Human Services waivers to federal rules for state demonstration projects in child support that "neither disadvantaged children nor increase federal AFDC costs." (13)

More broadly, the ability of effective child support enforcement to prevent poverty among children holds great promise. Adequate support orders in the first place are essential. Including medical benefit coverage as part of these orders could be of great help in Texas as it has been in other states. A monitoring program that begins as soon as court orders for child support are made, notes when a missed payment occurs, and uses court-appointed guardians ad litem to pursue the cases, can greatly improve enforcement. One Dallas County District Judge has initiated such a program in his court with considerable success. Other ideas must be tried out as well. The U.S. Bureau of the Census Data for 1981 showed that only 60% of the women potentially eligible to receive child support were awarded it, and of those, fewer than half received full payment while 28% received nothing at all.

Thus we see both promise and limitations. The ability of absent parents to pay is often limited. In out-of-wedlock births to teenage mothers, the father is often a teen also, still in high school. Others may be unemployed or chronically underemployed. While the responsibility to support one's children is not diminished by circumstances, the practical ability to do so is another matter, one that raises broader social questions that relate to economic opportunity in areas of severe poverty such as the inner cities and the Rio Grande Valley.

Having examined the components and found them severely lacking, it is not surprising to find that the "system" is failing to adequately address the needs it was designed to address. The following attempts to illustrate some of the shortcomings of our current system.

The combination of AFDC/Medicaid and foodstamps give a dependent family 48% of the resources needed for subsistence. With the exception of $50 per month in child support payments (when child support is available and no matter how many children in the family), an AFDC-dependent family may not supplement that amount in an attempt to achieve at least a subsistence level without losing the AFDC grant almost dollar-for-dollar. For example, a mother of two children receiving $184 in AFDC benefits locates a part-time job earning $225 per month (15-16 hours a week at minimum wage), she will gain for her family a total of $45 a month in expendable income (about $10 a week) and will lose $24 of that from a lowered foodstamp eligibility. In all, the will have added $21 to her family's monthly budget which would then equal 51% of the poverty level for a family of three. Here is the worksheet than an eligibility worker might produce for this case:

Mother of Two With Earned Income:

1.	Gross Income (from part-time employment)	$ 225.00
2.	Work-related expense	- 75.00
		$ 150.00
3.	Child Care deduction	- 75.00
		75.00

4.	Earned Income Disregard (Subtract $30 and 1/3 of the remainder for four months and then allow only the $30 for up to eight more months.)	$ 45.00
5.	Adjusted Net Income	30.00
6.	Recognized Need	184.00
7.	Less Adjusted Net Income	- 30.00
8.	Unmet Need	154.00
9.	Recommended Grant (for four months)	$ 154.00

Some explanations to further understand this worksheet:

#2 - Work-related expense. A full-or part-time worker may keep $75 or about $2.50 a day to cover such expenditures as transportation, work clothes, etc.

#3 - Daycare. The actual childcare expense, but not more than $150 per month for part-time workers or $160 for full-time per child.

#4 - This is the "work incentive" part.

#5 - #9 - Adjusted net income is deducted from the maximum grant amount and a new grant amount is set.

If we add the $75 (#4 and #5) to the new grant, $154, we see that the family is gaining $45 for the month. Yet after recalculation of the foodstamp benefit using a similar type of process, but with different federally-mandated criteria, we find the family has lost $24 in foodstamps for a net gain of $21 for 67 hours of labor. After the first four months, her earned income disregard is lowered to $30 and then her adjusted net income of $45 reduces the grant further to $139. For the next eight months she has a family income of $214 and $165 in food stamps equalling $379 (50% of poverty) for a net gain of $10 for her 67 hours of labor outside the home. When one considers the time away from a child or children, possible complications of finding transportation to a childcare facility then to and from work to the childcare facility and home again, such a gain of $10 could actually be more detrimental in the quality and quantity of time loss in caring for a child at home without working. After twelve months, there is no incentive to continue as each dollar earned is subtracted from the grant and will actually result in a loss of $11 in foodstamps.

As discouraging as this example may seem, the plight of the mother who enters a full-time job is often little better. Based on calculations by the University of Texas Bureau of Business Research in 1984, if our mother of two had worked 40 hours a week at $3.35 for 52 weeks a year, she would have grossed $6,968. Her expenses based on the Bureau of Labor Statistics' lower living standard would have been $7,848 plus child care and medical expenses. For the first four months after she left AFDC due to earned income, she would have retained Medicaid benefits for her family and, if she had been fortunate enough to be among the 25% of those eligible for subsidized daycare who could be accomodated in this vastly underfunded component, that expense too might have been covered, at least to some extent, during her employment. In the best of circumstances, for four months this family--after taxes--might

have reached 86% of the BLS lower living standard. After four months however, she could no longer have had the Medicaid coverage and would be most unlikely, in her low-wage job, to have had any medical coverage. She may easily have a child care expense of $200 per month. If she incurred the predicted $1,148 in medical expenses for the year, she would drop back to a level equal to 59% of the BLS lower living standard. (14)

Comparison of family budgets

A minimum wage earner ($3.35 an hour) with no medical or child care assistance fares worse than a family totally dependent on Aid to Families with Dependent Children (AFDC).

A family of one parent and two children need to have a yearly income of $12,613 to meet the criteria for the U.S. Bureau of Labor Statistics' "lower living standard." The hypothetical families below have been attributed various circumstances and the resulting incomes are compared to lower living standard.

Family 1 receives no government assistance but has a contributory health insurance plan through employer.

Family 2's child care and medical expenses are totally subsidized by the government.

Family 3 receives no assistance and is not covered by health insurance.

	Working families			AFDC
	Family 1	Family 2	Family 3	family
Hourly wage	$6.06	$3.35	$3.35	0
Yearly income	$12,613	$6,968	$6,968	$6,375[1]
Yearly expenses[2] (excluding the following two items).	7,848	7,848	7,848	7,848
Medical care	1,191	0	1,548	0
Child care[3]	2,400	0	2,400	0
Income taxes[4] and social security	1,174	273	89	0
Total yearly expenses	12,613	8,121	11,885	7,848
Percent of lower living standard	100%	86%	59%	81%

[1]Average yearly cost for AFDC grant, food stamps, Medicaid, and vendor drugs.

[2]Adjusted from national average for Texas.

[3]Full-time for one pre-school child or part-time for two school-age children.

[4]Includes federal credits for child care and earned income.

Staff Graphic by Mark Frensted

Source: Austin American Statesman, 1-26-86

This final example is based on the typical AFDC caretaker, a minority female of approximately 28 years of age. She has two children under 10 years old and no other income except her AFDC grant of $184 per month. The father of the children is absent from the home and provides no support. His whereabouts are unknown. She is unemployed, having dropped out of school at the 8th grade and having had no job training.

Let's say this mother has one child in school full-time and another at home. She volunteers to register for employment services at DHS and enters a job in the service sector for $3.50 per hour, 40 hours a week with no medical benefits. She has become a "successful" placement by all current definitions as she is now in full-time unsubsidized employment and her AFDC grant can be terminated. There were no subsidized daycare slots available when she took the job offer (the usual waiting time is at least 30 days), so she arranged for a neighbor to provide all-day care to the younger child and before and after school care to the older one. This costs our working mother $60 a week, a much lower amount than a local daycare center had wanted for the same number of hours (75 child care hours per week). Bus transportation costs her $1 a day; she brings her lunch from home and was able to keep clothing costs down by going to a used clothing store.

This mother is bringing home about $120 a week after taxes and from this she

is paying out $65 a week in work-related expenses including child care. She has $53 left over or about $236 per month to pay her rent, utilities, buy her clothes for work and those of her growing children, buy food (with some help from foodstamps), cleaning supplies, school supplies, non-prescription drugs, etc. After four months she will have to pay for all medical bills incurred by the family. This woman, who may start at 5 am in the morning to prepare her children for the day; herself for work, to walk the children to the daycare provider and catch one of the two buses she must take to reach her job at 7 am, returns home at 4:30 pm, picks her children up from the sitter's and walks to the grocery store and heads home to fix dinner and respond to the demands of two active children who have not seen their mother all day. Her family is now living at about 53% of the poverly level and we call her a success. Yet chances are good that if one of the children were to incur any significant amount of medical expense or if she were to become ill, she will literally be forced to leave the job to regain the Medicaid benefits needed to cover this essential care.

These situations illustrate a vital point: Preparing AFDC mothers for low-skilled, low-paying jobs does little or nothing to resolve the problems of children in poverty. It creates the illusion that something is being done, when in fact nothing has really changed for these children. Presented with the challenge to reduce AFDC rolls with grossly inadequate resources, the Department of Human Services Employment Services Programs have set their goals tragically low "to place as many AFDC recipients as possible, at acceptable costs, in jobs of at least 30 hours per week which pay at least federal minimum wage, $3.35 per hour." (15) The effect of these programs when they do lead to a "successful" job placement is to reduce the numbers of persons who are being assisted by AFDC and Medicaid. They do little to change the level of family income or the chances that the children involved will escape the destructive effects of poverty on their futures.

To recap, mothers who are motivated and ready to be self-supporting are often faced with any of a number of obtacles to this goal:

1. Lack of Job Skills. - almost no training is available to AFDC mothers in Texas and that which is available (JTPA) is mostly inadequate to meet the needs of a population with an average of an 8th grade education.

2. Lack of Jobs that Pay Enough to Support a Family - jobs that pay enough to make employment a sound choice for the well-being of the family. Jobs at or near the minimum wage without medical benefits are essentially of no economic advantage to the survival of the poor family with more than one child. DHS does not collect data on the starting wage of its AFDC job placements but for those entered from TEC in FY85, the starting wage averaged $3.75 per hour. The Bureau of Business Research estimates that a mother of two needs to earn $6.06 per hour to move out of poverty.

3. Lack of Support Services to enable the transition from welfare to work. Good, dependable child daycare services are essential for the mother who is training for and entering employment, yet only 25% of the known need is met with existing Title XX funds.

Transportation for families so poor that owning a car is rare presents another problem. Where public transportation is available, the need is for reimbursement while training and job-searching. In those areas where no public transportation exists, other arrangements should be worked out and transportation compensated for in some manner. Any system of employment and training that wishes to seriously address the need of AFDC mothers must provide for the complexities involved in child care and transportation both to the child care facility as well as to the potential job opportunities or the training for employment.

4. Loss of essential benefits, specifically, the loss of Medicaid can be a strong and perhaps even a logical disincentive or at least an unforeseen roadblock to the woman attempting to become self-supporting. Currently, a family can retain Medicaid benefits for four months after the grant has been denied due to new or increased earnings. In a few cases where very low income is being earned and AFDC eligibility is terminated due to loss of the average income disregards, nine months of additional Medicaid coverage is available.

5. Lack of incentives - our cases above have illustrated how little financial incentive is involved in current policies affecting AFDC/Medicaid and food stamps. Even the highly motivated must examine these disincentives when making decisions which will affect their ability to meet their family's basic needs.

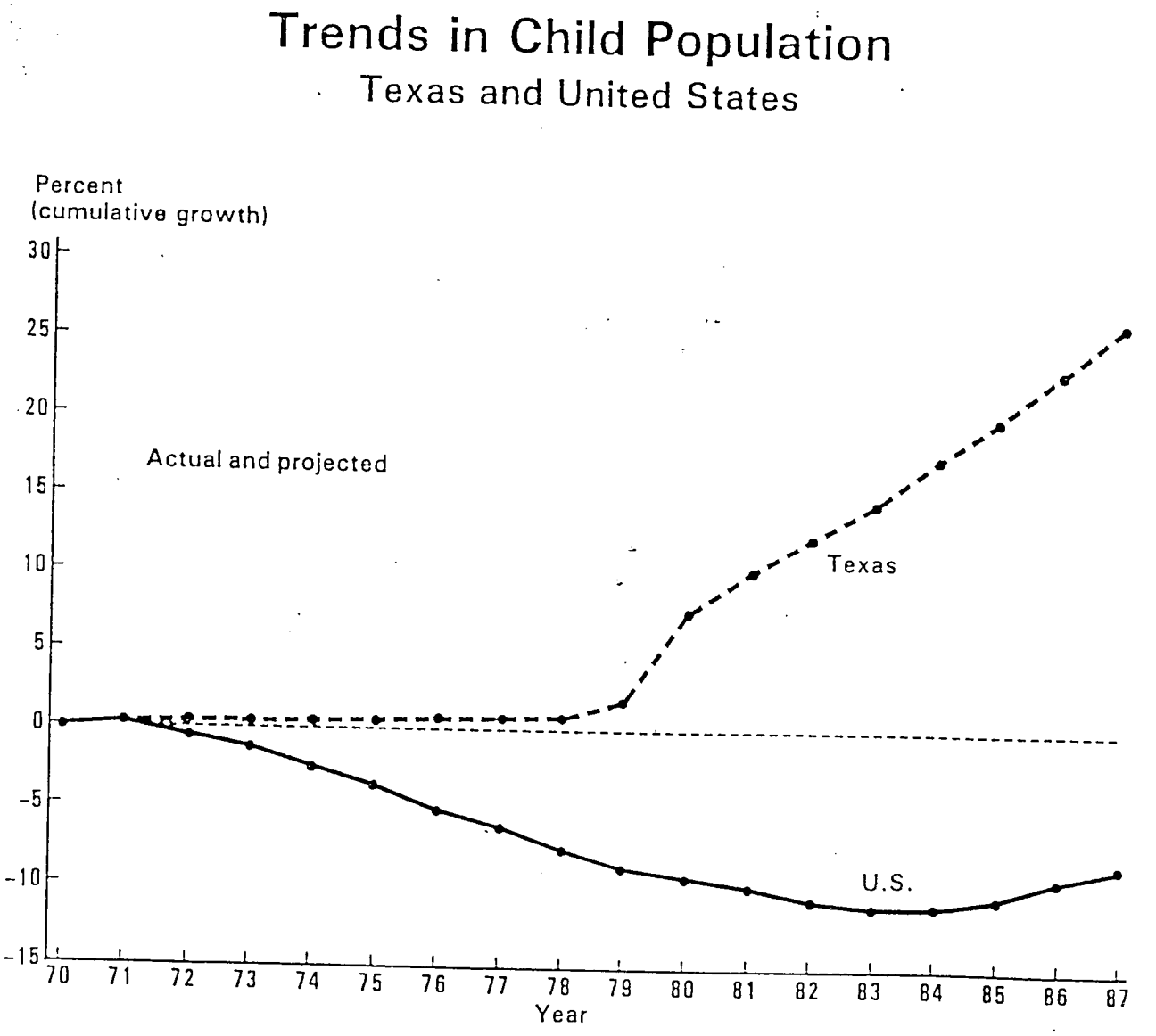
What we have seen in our examination of how well the current system of services meet the needs of Texas children in poverty is that this system--the primary public resources: child support, family self-support services and programs; employment programs--is not meeting existing needs in anywhere near an adequate manner. Individually, each program is restrained by policies and resource scarcity from reaching more than a fraction of those whom it was originally designed to assist, or as in the case of the AFDC grant, from making any significant progress in lifting Texas children out of poverty. Past and present efforts to assist family self-sufficiency through employment and training have been inadequate to the task and, without a dramatic change in strategy, can be predicted to bear a similar harvest of frustration and discouragement in the future.

Before moving on to address some of the options that Texas lawmakers have for changing this cycle of inadequate response, we will discuss three of the most important factors in the environment which will affect this system of services in the years ahead: changes in the Texas population and growth of the population in need as well as Texas' fiscal situation in the mid to late 1980's.

Projections of Need

The population of Texas has grown rapidly in recent years placing a severe strain on all public services. Even as this rate of growth seems to be moderating, we are still struggling to catch up. While the overall population has grown, the child population has grown at an even greater rate During a Budget and Oversight Subcommittee Hearing in February, 1985, the Department of Human Services reported that Texas has already experience

and will continue to experience an increase in child population that will run far ahead of the United States trend:



Texas Department of Human Resources

Specifically, information provided to this Committee by the Budget and Planning Division of the Department of Human Services on January 2, 1986, indicates a steady increase in the number of children in poverty in Texas both in terms of actual numbers and as a percentage of total child population.

Number of Children Living in Poverty in Texas

Year	No. of Children	% Increase Over Previous Year	% of Total Population
FY81	921,838		20.9
FY82	944,350	2.4	21.0
FY83	968,320	2.5	21.1
FY84	993,845	2.6	21.1
FY85	1,020,927	2.7	21.1
FY86	1,049,923	2.8	21.4

Cumulative 5-year Increase = 13.9%

As the numbers of children living in poverty has increased, the ability of the Texas AFDC program to provide assistance, given current categorical and financial eligibility restrictions, will remain limited. In information submitted by the DHS Budget and Planning Division, the following are the growth projects for the AFDC caseload at the current grant level of $57 per month per recipient:

	AFDC Cases (families)	% Increase Over Previous Year
FY86	131,401	6.9
FY87	140,431	6.9
FY88	150,082	6.9
FY89	160,395	6.9
FY90	171,417	6.9
FY91	183,196	6.9

Cumulative 5-year Increase = 39.4%

Clearly, as currently constituted, the Texas AFDC program will not keep up with the overall anticipated increases in child poverty. The poor children in two-parent families who are categorically ineligible will increase in number as will the number of children in single parent households who are currently ineligible because family income exceeds 48.2% of poverty.

As the United States child poverty rate has grown from 16.4% in 1979 to 22.2% in 1983, there is nothing to suggest that this nationwide poverty rate will reverse in the near future. Indeed, the near future is already apparent, for it is the youngest children who suffer the highest poverty rate. In 1984, 24% of the children younger than six were poor compared to 20.2% of those children age 6-17. (16) Texas, meanwhile, which had at 21.4% in 1986, a slightly lower child poverty rate than the nation, may soon exceed the national average if it has not already done so. The economic slump which has hit Texas hard and has given us an unemployment rate higher than the national average will surely affect the child poverty rate in both one and two-parent families.

Even if the child poverty rate in Texas could be kept constant, that rate multiplied by a growing child population will result in many more children living in poverty in this state in the near future. Additionally, if the poverty rate increases, as current trends indicate they will, then the total number of children living in poverty will be higher still. If we consider then the disruption in family relationships that accompany economic hard times, and the fact that Texas has one of the highest rates of teenage pregnancy in the nation, the number of poor children who may be living in conditions of poverty in this state in the coming years is ominous and will inevitably drain resources in other areas of state services and have a negative impact on all segments of society.

In this state, we have rightly committed ourselves to an improved system of public education as a means of achieving a long-term diversification and improvement of our economy. However, the prospect that as many as one in four of our children who enter the school system may be from a poor family raises serious questions as to how far we can improve our schools as long as so many children will require the remediation that a poverty background so often necessitates. As these children move through the schools, they will require a larger share of the education dollar just to catch up, and this will limit the overall improvement of our schools--and many will never catch up. Absenteeism and drop-out rates are closely related to poverty and these can only be expected to increase as the number of children living in poverty increases. As these children grow older and give up on society, as society gives up on them, we assume the greater burden through rising crime rates and pay the higher price through demands on the criminal justice and penal systems.

There are many who believe AFDC and other programs designed to assist poor families is the cause of these problems rather than the cure. They believe that such programs of assistance foster a "something for nothing" attitude that affects children in families who receive assistance, and it is this attitudes which affects children in families receiving assistance and leads to their failure in school and in life. It is difficult to accept how failing to provide basic food, shelter, medical care, clothing and school supplies to children who live in households without any financial means and in which opportunities for self-sufficiency are severely limited or perhaps non-existent, will engender a self-reliant attitude that will overcome the debiliatating effects of a childhood overwhelmed by hunger, homelessness, disease, abuse and inadequate education--all of which are sure to increase with the withdrawal or continued diminishment of public assistance for children.

Problems in the current system are not to be found in the necessary help that is provided but in the way that help is given. The current AFDC program, with its red tape, bureaucratic tangles and disincentives for self-sufficiency, can create a sense of hopelessness in families who are forced to rely on a system that is rarey adequate and generally not compassionate. Direct grants of assistance as currently provided with AFDC are often necessary but unless such assistance is seen as only a part of a larger system of assistance which offers opportunities for self-support, the basic problem of public programs will continue and long-term dependency will result.

Texas Fiscal Situation

As the federal government continues to shift the burden of social services to the states, it is our challenge to meet these needs. At the same time, we are well aware that this shift in responsibility could hardly have come at a more difficult time in our state.

In February, 1986, Comptroller Bob Bullock issued a revised estimate of state revenues that was $1.3 billion below the estimate used to certify the Appropriation Bill. Governor Mark White, on February 18, 1986, called on all state agencies to submit a plan to reduce overall expenditure by 13%. In their response to the Governor and in a public hearing before our Budget and Oversight Subcommittee, DHS Commissioner Marlin Johnston explained why such cuts are difficult to achieve in human services programs. These programs tend to be direct grants to the needy and do not involve large numbers of state personnel. An exception to this would be Child Protective Services, but these workers are charged with the responsibility of investigating reports of child abuse, and any personnel cuts would directly affect the already strained ability of this state to intervene in cases of abuse and serious neglect. The main difficulty that the Department faces in trying to reduce the outlay of state dollars is that, almost across-the-board, state dollars are matched with a federal dollars on a one-on-one ratio.

Such is the case with AFDC grants as it is with Medicaid reimbursements for both purchased health services for AFDC children and nursing home placements for the elderly. In other words, for most major programs, a dollar cut in state spending will result in the reduction of assistance by two dollars. Other programs including child care and family-planning services are facing reductions under Gramm-Rudman-Hollings that could total $38.2 million in FY87.

Funding for programs for the needy in Texas is in a double bind. Cuts in federal funds—and shifting repsonsibility to the states is occurring at a time when our state government is facing declining revenues. Yet, to cut back on essential programs which are already poorly funded would seem a short-sighted decision which will surely cost us far, far more in the future. This seems especially true when we are talking about programs for the children of this state. These children are our state's future.

Adequate funding for all state programs and services will be the issue of the highest importance for the 70th Legislature. Human Services Programs and assistance for children in poverty will be competing as always with other programs in the state. However the basic funding of state government is resolved, either through budget reductions or increased revenue or a combination of both, the issue that is more to the point is one of priority.

As we look to the future; are we prepared to recognize the importance of the young children in this state, to acknowledge their future is our future? Are we prepared to recognize that other state priorities and goals that have recently commanded our attention will be adversely affected by ignoring the needs of the nearly 25% of the children who, as they enter the public schools in the years to come, will have spent their first five years in poverty?

Over the years Texas has consistently been near the bottom in public assistance when ranked with the rest of the states. In recent years, years in which the Texas population and state budget have experienced tremendous growth, our commitment to the needy has diminished. According to a report by the Texas Research League, Texas, in 1970, spent 65.28% of the average state's per capita expenditure on public welfare and ranked 34th among the states. By 1984, per capita spending for public welfare was 48.18% of the national average, and Texas ranked 48th among the states.(17) That same report indicates that in 1984, Texas ranked 49th among the states in employees of state and local government in the area of of welfare with eight full-time employees per 10,000 citizens or one-half that of the national average. By contrast, Texas ranked 21st among the states for state and local government employees overall with 488 full-time equivalent employees per 10,000 population, or slightly higher than the national average of 472.

As the state budget grew over the past ten years, the portion of the state budget for human services grew at a slower rate, capturing an ever-decreasing percentage of the total budget.

> Over the entire period (1974-1983). . . human services actually grew at an average annual rate of 10.9% compared to a statewide average rate of 13.3%. Likewise, human services expenditures adjusted for price increased at an average annual rate of 2.3%, while total state expenditures adjusted for price reflected an average rate of 4.6% per year. (18)

In the report just cited, human service expenditures were further studied as adjusted for both price and population. This analysis reveals that, "human services expenditures adjusted for price and population decreased -4.18% from 1974 to 1983. While state expenditures adjusted for price and population increased an average of 1.7% each year, human services expenditures decreased at an annual rate of -.47%."(19)

When the report focuses on AFDC specifically, it indicates that from 1974 - 1983, AFDC expenditures adjusted for price and population "decreased by $95.9 million, or 60.8%, representing an average decrease of 9.9% per year." (20)

The point we are making is that human services programs in general and programs for children in poverty, in particular--always low by national standards--became a lower and lower priority during a time when state spending and state revenues, as well as state population, were all dramatically increasing. In 1974, human services programs comprised 19.1% of total state expenditures. (21) For the current biennium, human services programs account for 14.6% of the total state budget. (22) Had we maintained that 19.1% which existed in 1974, then, at that rate for the current biennium, $1.5 billion more would have been available for all human services programs, or a total of

$7.0 billion instead of the $5.5 billion that is appropriated.

TOTAL STATE BUDGET	FY 1974	FY 1984
TOTAL STATE BUDGET	$4,425.8 million	$18,517 million
Total Funds All Sources For Income Assistance	245.4 million	367.9 million
Income Assistance as a Percentage of Total State Budget	5.5 percent	2.0 percent

Clearly, in recent history, the decline in funding for human services has not resulted from a lack of state revenue, but because we have consistently and steadily reduced our level of commitment to these programs.

In light of this decline, we may conclude that the ability to find the financial resources to deal effectively with the issue of child poverty is limited less by anticipated reductions than it is by the priority we place on providing children and their families needed assisstance and the means to achieve economic self-sufficiency.

TEXAS' OPTIONS FOR ELIMINATING CHILDHOOD POVERTY

This report assumes that it is the desire of the individual members and the collective membership of the Texas Legislature to work toward the long-term goal of eliminating childhood poverty in Texas. This assumption is based on the fact that failure to provide for basic human needs at least at a level "consistent with decency and health" or the poverty level, will result in long-term costs to the state in the impaired function of children into adulthood.

> Current statistics indicate that nearly 60% of all pregnant women living below the poverty level in the United States consume food with such low nutritional level that brain development in their children even before birth is below normal. (1)

These costs include those involved in remedial education; special education; juvenile justice programs; alcohol, drugs and mental health services; the law enforcement and "corrections" system, as well as the public costs of chronic illness, unemployment and underemployment. The continuing economic liability that neglect of the basic needs during childhood produces could be a serious problem for the emerging Texas as an educated, economically diversified, technically oriented state. Current efforts underway to invest in our educational system and in technological research could be greatly hampered by the drain of resources needed to ameliorate the effects of such neglect on the one million Texas children who today live in poverty.

While a comprehensive and in-depth study of the State's system of services to poor families and children is clearly in order, this report will point to some important targets for action in the interim period. These actions are three areas of concern: prevention of childhood poverty; assistance to families in poverty that will lead to self-sufficiency; and improvements in benefits for those who need temporary assistance and those who, due to disabilities, may never be self-supporting, but whose children need and deserve opportunities for an independent future.

Prevention

If our objective is to eliminate childhoood poverty and family dependency in Texas, we must begin by enhancing our efforts at preventing these tragic situations from occurring.

Earlier we noted that the primary causes or correlates of AFDC dependency in Texas were:

1. Out-of-wedlock births
2. Separations or divorce followed by little or no child support
3. Unemployment and underemployment (which we now see includes full-time work at or about the minimum wage when trying to support a family today).

In addressing efforts toward the prevention of the above situations, we will focus on three options:

1. Reductions of teen pregnancy and the prevention of unplanned, out-of-wedlock births in Texas

2. The preventions of "dropping out" before the completion of high school or a technical or vocational education

3. Improvements in Child Support Enforcement efforts which will direct responsibility for the sustenance of children to all parents who are capable of contributing such support

Teen Pregnancy/Unplanned Pregnancy

While the attention of the nation is on the epidemic of teen pregnancies, the problem in Texas is particularly acute. We place third among the 50 states in the number of pregnant teenagers and first in births to teens age 14 and younger.

In 1982, the most recent year for which we have data, 46,987 babies were born to young mothers between the ages of 10 and 19. (2) In Harris County alone, 7,560 infants were born to teens from 12-19. Forty percent of these births were to unmarried women, but since teen marriages have such high dissolution rates (90%), we can take little comfort in the fact that many pregnant teens are married at the time they give birth. Records from the Texas Department of Health indicate that only 23% of all births to Texas teens were intended or planned, but 95% of teens who give birth keep their babies and the state is seeing an increasing tendency toward single parenthood.

A separate report on this topic has been prepared by the Human Services's Committee's Subcomittee on Teen Pregnancy and should be reviewed for further discussion or recommendations.

It is important to recall, too, that it is not just teens who are experiencing out-of-wedlock births. Over 26,700 out-of-wedlock (and presumably unintended) births occurred to Texas women age 20 or above in 1984 and they accounted for 60% of all such births that year.

If out-of-wedlock birth is the number one factor contributing to AFDC dependency and if unintended pregnancy often counters the efforts of dependent families to become self-sufficient, it is clearly in our interest to increase efforts in the area of family planning services. Currently, the State invests less than $2 million of its own money in the major family planning programs--Title XIX which serve women who are poor and pregnant already or who are already on AFDC, and Title XX which can serve any low-income person. This amounts to less than 14¢ per person in the state. For the average cost of less than $80 per client, family planning clinics provi ed not only counseling and a full year of contraception, but health screening for breast and cervical cancer, veneral disease, infections of the reproductive tract, hypertension, anemia and kidney disease. Studies have demonstrated the cost-effectiveness of investing in family-planning services simply in offsetting public cost for prenatal care and delivery. If an unintended birth results in the creation of a new AFDC-dependent family, the failure to provide preventive services is costly indeed.

Prevention of unintened pregnancy is the most cost-effective means of reducing the number of children in poverty. In the short term, Texas must not allow any erosion of funding to family planning services now being provided. With Title XX (Social Services Block Grant), funds facing a possible 20% cut--and since it is those funds most likely to provide primary prevention, Texas must make a commitment to replace any lost federal dollars with state dollars to maintain services at least at current levels.

In the long term, Texas will be wise to increase its commitment of resources to high-quality, accessible family planning services, to increase public awareness of such services and make them available to all Texas residents at risk of unplanned pregnancy. The Texas Department of Health and the Texas Department of Human Services working at the highest levels of coordination and cooperation should create a joint plan of action to achieve these goals. Efforts of the special Teen Parent Inititative task force now operating among TDHS, TDH, TEA and TDMHMR should be encouraged and supported as a model for addressing complex state problems in a coordinated approach.

Dropping Out

A second kind of activity which can help prevent childhood poverty and lack of family self-sufficiency is the prevention of early withdrawal from the formal education system (dropping out) which so often leads to a lack of skills and inadequate earning potential.

The extent of the drop-out problem in Texas is not known at this time as there exists no systems of recording such data statewide. In fact, there does not exist a uniform definition of the term "drop out" with which

to begin collecting such information for planning and intervention purposes. The estimates sometimes used are that approximately 30-35% of all Texas youth leave school before completing their secondary educations. Such an alarming drop-out rate is the most immediate consequence of a school system's failure to meet the needs of these children.

The Texas Education Reform Act (HB 72) began to focus on this critical problem by directing a statewide research effort as the first phase in the development of a comprehensive prevention program. A report to the Legislature submitted by the Texas Department of Community Affairs in conjunction with Texas Education Agency, The Texas School Drop-Out Survey, will provide more information on this effort.

We do know, from national studies of the problem, that students from poor families are three to four times more likely to drop out of school than their non-poor peers, regardless of race. Currently, in Texas any student in high school or a vocational or technical program who turns 19 and has not completed his/her secondary education will be dropped from the AFDC/Medicaid Program. The State should strongly consider extending benefits at least to age 20 for students reasonably expected to graduate. The State may be able to receive federal matching funds for aid to such children by allowing the child to be designated as a "needy essential person" in the household.

The pilot Teen Projects in Houston and El Paso are likewise important opportunities for investigating strategies of school retention for a particular target group of teens at risk of dropping out. All attempts to encourage and enable our young people to finish at least the basic twelve years as a preparation for employment (above the minimum wage) can assist in reducing Texas' poverty rates and promoting self-sufficiency in the years to come. The strengthening of the basic educational system is an important part of this effort, but much more needs to be learned about the needs of those students who, through discouragement, dis-interest, lack of resources, family finances, pregnancy or parenthood, or whatever combination of forces, are not completing their basic educations. The Committee considers any efforts to encourage completions of secondary education to be valuable strategies in the prevention of childhood poverty in Texas.

EDUCATION, TRAINING AND EMPLOYMENT OPPORTUNITIES

Several states have begun taking positive first steps to assist AFDC clients' transitions to independence through employment. State and local efforts are demonstrating the potential for integrating employment and welfare policies by combining innovative approaches in education, training, job placement, social services and economic development. The most effective programs are making intensive investments in vocational training, remedial educations and supervised work experience for AFDC recipients.

While these innovative state and local programs are new, and for the most part, evaluations are preliminary, they share two common features. The first is a willingness to invest in women living in poverty; the second is a willingness to offer a range of choices to those seeking self-sufficiency. They use the resources of AFDC and WIN systems to design a ladder out of poverty for their clients, offering both training and support services such as daycare and transportation to women making the transition to work.

What can Texas learn from these new models that will help this state's poor families achieve the economic independence they want and need and which the State also wants and needs? Clearly, we need to change the pattern of underfunded and poorly targeted efforts to date that have been largely unsuccessful in increasing employability and job opportunities in Texas. Currently-operating programs are mostly concerned with numbers of persons placed in jobs--a situation that leads to placements that, first, serve the easiest to place (those most likely to have found employment on their own) and second, provide inadequate income and benefits to lift families out of poverty and end dependency on a more permanent basis. The emphasis, at least in recent years, has been on quantity at the expense of quality of job placements, and the quantity has been unimpressive as well.

Texas is not unique in this regard. Virtually all the states have suffered through similar attempts to make an impact on their AFDC caseloads with programs aimed at employment. Most have had similarly poor results with the limited federal and matching state resources that were made available for their efforts since 1967 when WIN was first enacted. A recent Government Accounting Office report states:

> "As a consequence of funding limitations, WIN has only been able to provide services to a small percentage of the AFDC caseload, and has generally targeted those recipients who are most readily employable, and least expensive to serve." (3)

Since 1981, when the President made his first unsuccessful attempt to abolish WIN and replace it with a mandatory workfare requirement, Congress has granted states the authority to implement a WIN Demonstration Project as an alternative to the regular WIN program. The major difference between the two has been that the demonstration program is administered solely by the welfare agencies at the state level (e.g., DHS) and the Department of Health and Human Services at the federal level, thus eliminating as co-administrators state employment agencies and the Department of Labor. WIN Demo also permits states additional flexibility in designing the programs. Some states, such as Massachusetts, Maine and California, have taken this flexibility and created what are being described in most circles as major programmatic innovations with dramatic impact potential. Most notable about these programs is that they are truly comprehensive and they target a good portion of their efforts on those whose skills and education level and work histories have made them the hardest to place. They appear to have broken out of the cycle of low investment/low expections/low results and accepted the challenge to invest in the human potential of their AFDC families in a way that will enable them to share more equitably the abundance of this nation.

Although eleven states have developed WIN Demonstration programs of various types (including Texas), three states have created models which emphasize the goal of developing human capital to achieve long-term self-sufficiency.

Maine

Maine's WEET (Welfare, Employment, Education and Training) Program was actually being conceived before the 1981 Omnibus Budget Rehabiliation Act which authorized WIN Demo initiatives. Three kinds of information influenced

the design of WEET: findings of a special task force created by the Commissioner of Human Services, a 1980 Urban Institute Study of the characteristics of high-performing WIN state programs and data on Maine's job market. The task force attributed the low performance of the state's employment and training programs to restrictions on training and supportive services and to funding formulae that rewarded these programs for working with the easiest to employ--among whom were "precious few women on welfare."

The Urban Institute study had found three characteristics common to the most effective WIN programs: client-centered case management, significant levels of social support services, and substantial job search training. Finally, the WEET planners focused on the fact that Maine is a poor state with two-thirds of its jobs in trades or services, often low-paying, part-time and seasonal. Given its economy and the limited education, skills and work experience of many AFDC clients, they recognized the need for more intensive training and education if they were to have an effective program. (4)

The basic components of Maine's WEET include the assignment of each client to an employment specialist who becomes the case manager for the client. This WEET specialist performs the initial employment assessment, develops with the client an Employability Plan and monitors the plan thereafter. The specialists are also responsible for job search assistance and job development and placement. After the assessment, which focuses on job readiness, the client and specialist decide whether to move immediately to job search or to seek job training. (All long-term AFDC recipients are required to go through such a structured training sequence). The employability plan which results from this process includes an occupational goal consistent with the client's interest and aptitudes, local labor market conditons and, ultimately, economic independence.

Over 2,700 WEET participants entered training of some type:

WEET Clients
Enrolled in Training Activities

	Percentage
GED preparation	14
Adult/remedial education	16
Prevocational training	16
Volunteer work experience	11
CETA/JTPA skills training	9
Vocational technical programs	10
College programs	25

Although WEET specialists arrange directly for on-the-job training, they also refer some clients to JTPA for training as well. The program has worked closely with the state's education, training and economic development agencies, the displaced homemakers project, vocational schools and adult education programs. Because good jobs are limited in Maine, WEET

works with economic development agencies to locate newly created jobs for its clients.

Since WEET began in 1982, 9000 AFDC recipients have been assessed for employment potential and 4500 have obtained employment through the program. The average cost per placement has been $1,333. The average entry wage as of September, 1985, was $4.48; 40% of full-time jobs included health benefits. The Commissioner of Maine's Department of Human Services estimates the program has cost $6 million since its inception (35% of which has been used for supportive services) and has saved the state $5.5 million over costs from 1982-1985.

Massachusetts

Massachusetts began its Employment and Training Choices (ET Choices, or ET) Program in October of 1983. Since that time, it has placed over 23,000 AFDC recipients in unsubsidized employment at an average starting wage of $5/hour. (5) The program uses creative strategies and a careful design to offer a range of opportunities to its dependent caretakers which result not only in their departure from AFDC caseloads on a permanent basis but actually lifts them to an economic situation above the poverty level. The average yearly salary of a full-time employed ET Choices participant was $10,000 in 1985--double the average welfare grant in that state and 11% above the federal poverty level for a family of three last year. (6)

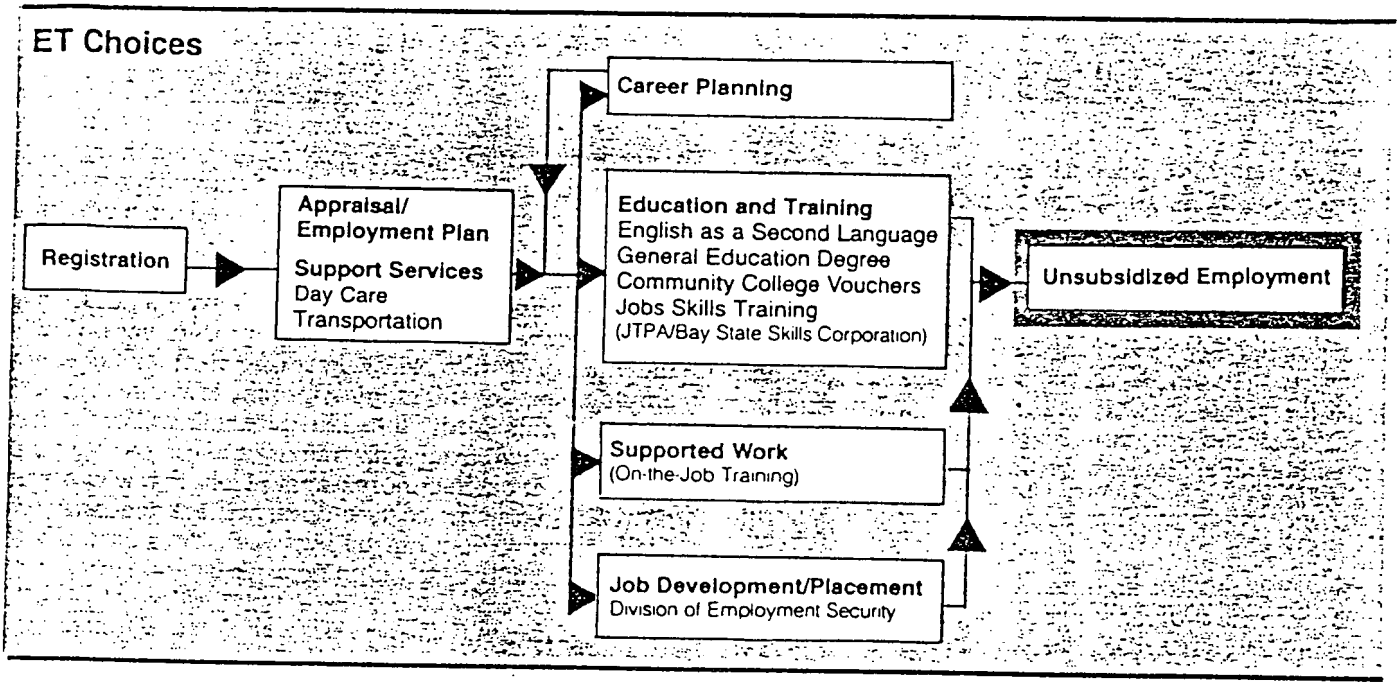
While Massachusetts has seen a reduction in its overall unemployment rate during the period ET has been operating, program proponents note that, whereas unemployment fell in all twelve states with the largest AFDC caseloads, the number of AFDC cases has risen in six of these states anyway, another way of saying that a strong economy is no predictor of low AFDC cases. Massachusetts has seen a 9.4% drop in its AFDC caseload since ET Choices began.

The designers of ET argue that "A rising tide lifts all boats" doesn't apply to most AFDC families who have no boats to lift. Their objective has been to help build boats for AFDC caretakers through education and training.

In ET, all mandatory and voluntary program registrants receive an appraisal (an assessment) and an Employment Plan which will lead to self-sufficiency. The client then chooses her next step - 45% decide to seek work right away and enter the Job Search/Job Placement component. The other 55% opt for some form or combination of education and training to prepare themselves for work. If a client chooses Job Search first and fails to find work, she may re-enter at another part of the system. Throughout the process, ET participants are given supportive services including subsidized daycare and reimbursement for transportation expenses. The daycare will continue up to one year after entering employment. Program managers stress the importance of these supportive services as absolutely essential to the success of their other effort in preparing clients for work. Massachusetts allocates 20% of its ET budget for essential support services.

As in Maine, the Massachusetts program relies heavily on cooperation, coordination and contracts with other agencies and groups within the state. ET Choices has been developed and implemented as a genuine partnership among the Departments of Public Welfare and Employment Security, the Legislature, the

clients, private employers, JTPA agencies and the state's Job Training Coordinating Council.



ET prepares people to become operating room technicians, welders, high tech assemblers and construction workers as well as clerical and service workers. Over 85% of the people who left AFDC caseloads through ET are still off one year later.

The key features of ET are its emphasis on training, long-term employment and choice. It is designed to help those least prepared to enter the workforce equally as those more job-ready. Over 36% of program component funds are targeted to the Supported Work Program in which AFDC recipients with little or no work history are prepared for permanent unsubsidized jobs through a unique system of supports and incentives. In this component, Supported Work contractors employ AFDC clients and place them in private companies and public agencies where they work and learn under the supervision of supported work staff members. The company pays a market rate fee to the contractors for work performed by ET participants. The three basic elements of the program are: on-the-job supervision; graduated stress and peer support. It is a model which has proven successful in assisting the least employable to become more self-confident, self-supporting workers.

While the average cost per placement for ET clients has been $3,000, it is important to note that that figure averages the lower cost of placing the more job-ready who choose to go directly to work with the higher cost of a Supported Work Program (and whereas half of Massachusetts' AFDC caretakers have a high school diploma-- some indication of their employability above the minimum wage; at last study, only 22-24% of Texas' AFDC caretakers had a similar advantage).

While another state's program design cannot be automatically translated to solve Texas' problems, the Massachusetts program has several features that may account for its success and which should be considered in any model proposed for Texas:

The emphasis on training and education as the keys to unlocking the potential of clients now seen as burdens rather than as resources, and to assisting them to make a strong transition to permanent self-sufficiency.

Its emphasis on choice that empowers the client to take charge of his (her) life decisions and responsibility for the consequences.

The leadership that has produced high visibility, high energy and a strong sense of cooperative mission, a "priceless" component that no amount of money can buy.

A significant commitment of new state dollars - almost $32 million of the 1984 budget of $40 million was state money - and the adequate provision of essential support services.

California

The final of the three models from which Texas can learn much is the new California Greater Avenues for Independence (GAIN) Program which is now in the implementation stages. Born of legislation passed just last fall, GAIN is modeled on a combination of successful program elements carefully sequenced in a cost-effective manner and targeted at specific groups. The goal of GAIN is to establish a means of improving work skills - whether through the shaping of job-seeking skills, building self-confidence, providing basic remedial education, on-the-job-training or any of a range of other vehicles that meet the specific needs of clients. (7)

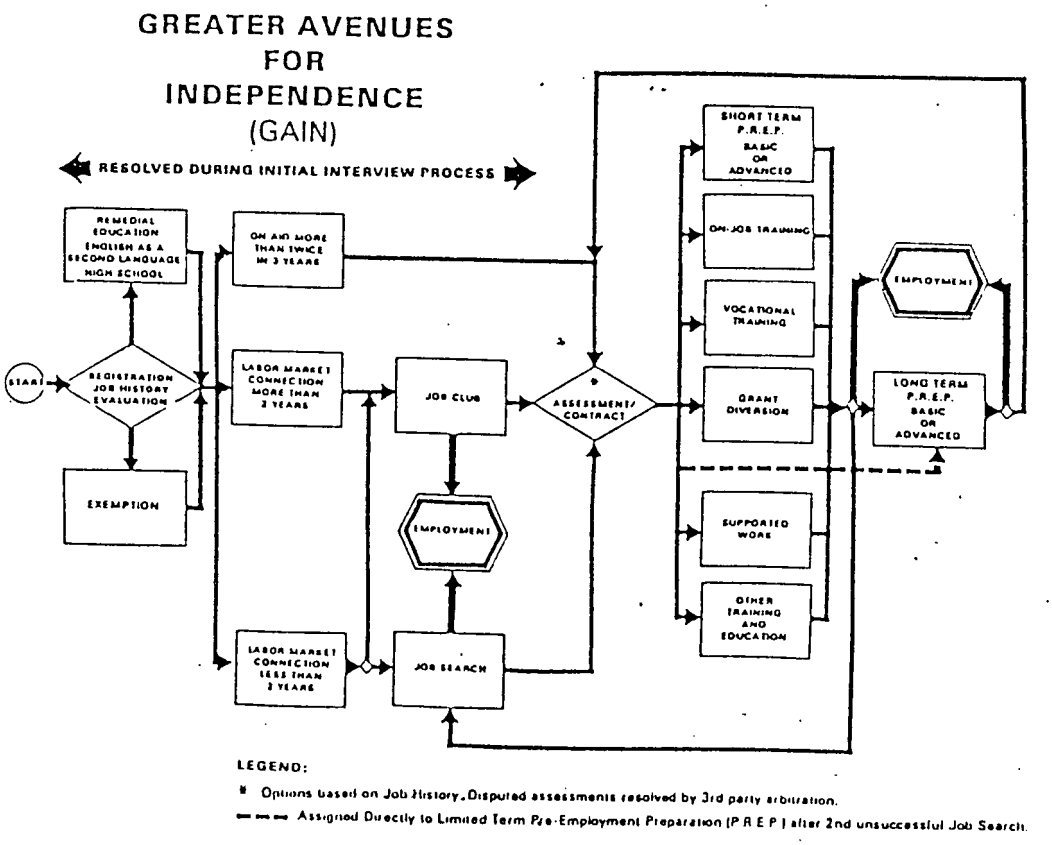
While not unlike Maine and Massachusetts in many ways, the California program design has one aspect which is very different - no one who enters the program gets "lost," ends up at a dead-end or in an "unassigned pool." The only way out of the GAIN Program is through employment.

Gain's network of sequential components differs from the above described programs more in its unique sequencing than in the actual mix of components. As in other states, all non-exempt AFDC recipients must register with the program and exempt persons may register voluntarily (although this latter group is not guaranteed services in California and may have to spend time on a waiting list). Recipients who need remedial education such as English as a second language or GED instruction receive those services right away, before going any further in the process. Recipients without special needs who have not worked in two years or more will be assigned to a three-week job club with workshops that teach job-seeking skills and then a supervised job search. Those who have been employed within the past two years may choose between job club and job search. The placement of job search activities "up front" is designed as a cost-saving measures that allows the marketplace to decide whether the recipient is employable.

Clients who have been on AFDC more than twice over the past three years are assigned directly to the program's second phase: assessment. Likewise, those

who fail to find jobs after job club/job search enter the assessment phase where clients are tested for aptitude, interest and achievement and receive counseling and evaluation. Participants then choose a course of action based on their background, their needs and the needs of the employers. The options include on-the-job training, vocational training, supported work, other training or up to two years of academic education leading to a specific employment goal. Based on the assessment and the options chosen, an Employability Plan is drawn up showing what actions the client must take to get a job. Finally, a contract is drafted between the participant and the county which specifies the responsibilities of each in achieving the goals.

Those not employed at the end of their training enter a 90-day supervised job search. Participants who are unemployed after the 90-days and trainees who fail to complete the education or training component are assigned to a third phase called pre-employment preparation or PREP for one year. PREP assignments are a mandatory work component, ofter referred to as "workfare," in which the client works in the public sector or in a non-profit agency and continues to receive her AFDC grant in lieu of wages. The client works enough hours at a specific wage formula rate (in California, it is the current average starting wage, or $5.07 per hour) to offset the AFDC grant and foodstamp value. Since the California grant is one of the highest in the country, many will work close to the 32 hours limit each week. Eight hours are to be used in job search activities. If the person is still unemployed after a year in PREP, the cycle begins again with an assessment and continues until the client attains independence through employment. All participants will be involved in some component of the sequence at all times, the most unique feature of the GAIN design. There will be no dead-ends for clients, "the program does not give up on anyone." Support services, child care and transportation are available throughout this process and for up to three months after the transition to work.



Source: Public Welfare, Vol. 44, No. 1

Components of the California GAIN program were taken from many areas of the country. The job search concept and the mandatory elements were borrowed from San Diego County's experimental work pilot project. The choices and assessment components, with some new distinguishing features were inspired by the Massachusetts employment and training choices program. Performance concepts that set job placement targets for those providing training services are incorporated from the locally administered Job Training and Partnership Act (JTPA). From San Diego, Pennsylvania, and West Virginia, GAIN adopted pre-employment preparation from the community work experience. Recipients' contracts with counties, the provision for no unassigned pool, and the division of pre-employment preparations into basic and advanced segments are new elements conceived in California. (8)

The California model is also unique is that significant amounts of flexibility are granted to the counties to manage the various components of the program. While each county will be required to offer the full range of education and training services, they will be autonomous in development and management of their services.

California views the design and development of GAIN as a major structural reform to its welfare system. Once the program is fully operational (projected as 1992), it is expected to cost the state $158 million a year to run and result in a net savings of $114 million.

These three states have undertaken the challenge to break the cycle of poverty and dependency. They have harnessed imagination and innovation in pursuit of a better system, not waiting for the federal government to give them new categorical funding with its concommitant new rules and regulations. Taking advantage of the flexibilitiy allowed under WIN Demo and making the major policy decisions to invest in the future of their AFDC caretakers and families, they have each committeed significant new state dollars in a carefully designed system that will pay them back not only in AFDC cost avoidance, but in taxes paid through work and purchases and in the human dividends of a better educated, more self-sufficient and self confident citizenry.

Texas' Challenge

Texas is at a crossroads in many respects. One of its first tasks needs to be to make a decision about the future direction of its public welfare program. If the long-term goal is to maximize self-sufficiency and minimize poverty, then a major effort must be undertaken in the area of employment training and education. Just as Maine, Massachusetts and California have taken lessons from earlier welfare employment programs so too can Texas look to the best of the efforts underway to learn more about how it can achieve its goals.

Some of the key aspects from these states' efforts that deserve scrutiny by those who may be considering the design of a similar program for Texas include:

1. The use of Employability Plans, unique to the needs of each client and with an emphasis on client participation and choice so that the plans which are developed include a personal investment on the part of the client.

2. The use of case managers who work with the client throughout their employment preparation and monitor the progress of employability plans. (Maine)

3. Sequencing of program components which involves some value decisions. For example, California's design places Job Search activity "up front," thus allowing the market to determine the client's employability. In Massachusetts, the choice is given to the client whether to seek employment immediately or prepare for something more satisfactory in the long run.

4. Formal contracts between clients and providers that set out the responsibilities of each to fulfill the Employability Plan. (California)

5. A contiuous loop model that keeps all participants actively engaged in the system using a "workfare" component for those who do not complete their education or training contracts or who cannot locate employment upon completion. (California)

6. Targeting the hardest to employ using remedial education, supported work and other strategies to truly impact the employment capacity of a good proportion of AFDC caretakers.

7. Adequate provision of support services, daycare and transportation that, when lacking, can subvert all other efforts to help mothers become family providers.

8. A statewide, grassroots-to-highest levels of commitment to changing the status quo which can break through bureaucratic roadblocks to cooperation and which make available significant levels of state resources to address problems.

9. Commitment of significant new state dollars (along with maximum utilization of federal resources) as the investment capital which will earn the state long-term dividends in more self-sufficient families and more Texas children with healthy and hopeful futures.

Texas has begun the process of examining its options in regard to AFDC employment reform. On February 26, 1986, the Governor's Office presented an AFDC/JTPA Employment Initiative to the State Job Training Coordinating Council's Policy Committee. This three-phase program seeks to build a new AFDC employment effort on a foundation of coordination and public-private partnership "to increase the number of job opportunities for AFDC recipients and ensure that there is a promise of successful long-term employment." (9)

Phase I of the plan consists of the promotion of non-financial agreements between local DHS offices and agencies administering JTPA. Such agreements are already in place in some parts of the state, and the majority of regions have adopted the model endorsed by the SJTCC.

Phase II involves the implementation by the Governor's Office of a one-year pilot program called the Corporate Coordination Model which will entail a personal solicitation from the Governor to Texas businesses encouraging their involvement in offering employment opportunities to AFDC recipients. Three pilot sites would be chosen and would be given a comprehensive program of pre-employment training, customized training and support services as well as follow-up activities.

Phase III involves an evaluation of the Corporate Model and the key element in all of this--research and development of a comprehensive employment program for AFDC clients that can be replicated statewide. The Chair of the SJTCC, Dr. Ray Marshall, will appoint an Advisory Panel to carry out Phase III activities. It is hoped that the panel will consist of people who can elicit high levels of cooperation among state agencies and the private sector and eliminate barriers to communication.

As envisioned, Phase III will have three components. The first, Research and Analysis, will review why Texans become public assistance recipients, analyze programs in other states and evaluate the Corporate Model's ability to foster economic self-sufficiency. The second component Design and Development, will include the design and implementation of a model program for the employment of eligible Texas AFDC recipients. The third, Evaluation and Assessment, will analyze the results of the model. Based on the results of this analysis, a decision will be made about whether to implement the model on a statewide basis. (10)

This approach, most particularly those activities described for Phase III, may provide the leadership needed for effective action in Texas. The Legislature and the public must stay informed about these developments as work progresses toward a sorely needed reform of our present situation.

Costs and Benefits

The long-term social benefits of an effective AFDC employment and training program have been articulated several times in this report. The actual dollar amounts of cost savings are somewhat more difficult to calculate. If Texas wants quick, short-term gains, it may need to look elsewhere, but if it is ready to invest for long-term dividends, there are clear signs that this approach can produce results.

The following cost estimate of an AFDC employment and training program in Texas is based on 1985 and 1986 data provided by TDHS and the Texas Job Training Coordinating Council and uses two approaches to calculating potential costs. The first estimates costs for Texas based on a comparison to approximate state costs of the Massachusetts' ET Choices Program and the California GAIN Program. The second approach calculates the amount of new state dollars needed based upon achieving a break-even point for the state's investment after one year of AFDC grant avoidance.

There are many variables which affect program costs and these will vary from state to state. The program design and client characteristics will have the most dramatic impact on costs. In Texas, for example, because of our very low grant level, it could be expected that the personal resources and thus employability of the average grant recipient will be lower than

that of California or Massachusetts.

Following the first approach, we find that Massachusetts is currently committing $40 million a year on its program with an AFDC caseload of 85,000 families. In Texas, we have an average monthly AFDC caseload of 126,000 families. All other things being equal, we would have to commit $59.3 million in state dollars to equal the Massachusetts effort:

$$\frac{\$40 \text{ million}}{85{,}000 \text{ families}} \qquad \frac{\$59.3 \text{ million}}{126{,}000 \text{ families}}$$

In California, officials anticipate spending $304 million a year on the GAIN Program with an AFDC caseload of 586,00 families. At that level, the corresponding ratio for Texas would be $65.4 million.

$$\frac{\$304 \text{ million}}{586{,}000 \text{ families}} \qquad \frac{\$65.4 \text{ million}}{126{,}000 \text{ families}}$$

In the second approach, we look only at Texas and attempt to estimate what a reasonable commitment in employment and training costs could be in this state based upon our current costs for AFDC. To do this, we calculate the amount of state dollars now being expended to support an average-sized AFDC family. The current average payment per family for an AFDC grant is $178 per month, or $2,136 per year per family. Of that, 46% is state funds, or $982.56 per year. State cost for Medicaid associated with AFDC is determined by the current Medicaid premium plus average vendor drug cost per month per person: $58.26, or $179.96 a month for the average sized family. That is $2,160 per year in benefit cost and the state's share (46%) of that is $993.60. The state's share of AFDC administrative cost would add another $160.32. (11)

Combining these three figures, we find that the State of Texas spends $2,136 per year on the average AFDC family of three. If we were to commit a like amount toward a program designed to secure jobs and permanent self-sufficiency for AFDC recipients, then, when successful, the State would come out even one year after the family becomes entirely self-supporting.

The $2,136 which would be spent for education, training, job placement and support services in a complete program is a relatively low figure. By contrast, Massachusetts estimates a cost of about $3,000 per client. California does not have a per client average but breaks the cost down depending upon the level of effort needed to place the client in an appropriate job. That breakdown is as follows:

$ 500 per client	Job Search only
$ 800 per client	Using Grant Diversion
$ 1,700 per client	Community Work Experience (PREP)
$6,000-8,000 per client	For services including Supported Work for the long-term structurally unemployed (in fact, many Texas AFDC clients will fall into this category.)

The $2,136 is a low number reflecting our very low grant amount and thus a lower cost-effectiveness when a family leaves AFDC. A figure any lower than this would raise serious questions about whether an effective program could be constructed that would contain all needed elements.

We next apply the $2,136 to the current job program caseload: In 1985, 36,735 AFDC recipients were required to register for employment. In addition, 26,034 persons volunteered to register for job placement for a total of 62,769 seeking jobs. If a similar number (62,700) were registered for employment services the first year of a new Texas employment/training initiative and an average of $2,136 were invested in each client, the program could be projected to cost $133.9 million annually. Not all of those dollars would need to be new dollars nor would they all be state funds. If we utilize JTPA funds as extensively as other states currently use them, the amount of new state dollars for the program would be reduced.

We might first calculate that of the total budget, 25% must be allocated for support services (child care and transportation). That would equal $33.5 million. There is currently $33.9 million in Title XX or SSBG dollars allocated to child care of which about 25% is being utilized in employment services support ($8,475,000). We would need $25.6 million in new state dollars for the supportive services aspect of a comprehensive employment/training program.

Deducting support services costs from total costs leaves $100.4 million for employment counseling, training and education. If 25% of JTPA funds could be earmarked exclusively for AFDC employment, $47.5 million could come from this source based on 1985 totals of $191 million in JTPA funds in Texas. It would require considerable effort by the State Job Training Coordinating Council, the Texas Department of Community Affairs, the Governor's Office and the local Private Industry Councils for that level of funds to be used in training AFDC clients.

The State's current (1986) commitment of funds for employment services along with federal funds available equal another $11.8 million available potentially to the program. Combining these resources, $47.5 million from JTPA and $11.8 million from the current budget for DHS AFDC employment services, produces a figure of $59.3 million available. Deducting that total from the $100.4 million needed for an approach which could have a one-year pay-back, we conclude that $41.1 million in new state funds would need to be committed for employment and training. Combining this with the dollars needed for the support services, we recognize a need of $66.7 million in new state dollars for the first year of a new and comprehensive program.

When we used the first approach of estimating costs based on comparisons with Massachusetts and California's caseloads and dollar commitments, we found that spending in Texas would have to be in the range of $59.3 to $65.4 million. The $66.7 million that we estimated we would have to spend using the second method, which considers our lower level of grant and reduced cost-effectiveness, is in this same neighborhood.

To recap: Of the $133.9 million total, $47.5 million could come from the JTPA given a high level of commitment and cooperation and $20.275 is available from current budgets. Of the remaining $66.7 million in state dollars needed, $25.6 million would be used for supportive services and $41.1 million

in employment counseling, training and education. The $66.7 million in state dollars needed to prepare 30% of the AFDC caseload for self-sufficiency compares to the $206.5 million we appropriated in state dollars each year of the current biennium for AFDC and Medicaid. The $2,217 per client we might average for education and training compares with $3,384 per pupil per year average expenditure in Texas public schools. (12) Long-term cost comparisons which may be considered are the $16,500 per year cost of one child in juvenile detention facilities and the $14,000 per year cost of an adult in the Texas penal facility.

We would caution that, given client characteristics of the Texas AFDC caseload, we cannot be certain that these figures would provide the full range of services which are available in the California and Massachusetts programs designed for success. A larger initial investment would mean a little longer pay-back period but may be more cost-effective in the long run if an incomplete program were the alternative. The evidence suggests that low-funded, incomplete approaches do not do the job of preparing AFDC clients for self-sufficiency. Clearly, Texas pilot efforts such as are being planned by the AFDC/JTPA initiative will provide the best cost data for a statewide program. These preliminary estimates allow us to have some idea of the range of cost involved.

Support Services

As noted previously, any comprehensive employment/training program must have a well-designed and adequately funded system of support services that will enable caretakers to accept the opportunities being offered to improve job skills and to enter employment. Much of the structure is already in place to provide subsidized daycare. What is needed now is funding at a level which can meet the needs of the majority of program participants who need this support. A system of reimbursing transportation costs must also be designed and funded. Finally, the State should consider how it might make medical benefits available beyond four months for more families leaving the AFDC program. (A small group of very low earners currently benefit from an extension mechanism which gives them nine additional months.)

The desired effect of a strong employment/training program would be that many AFDC caretakers will find employment which includes a medical-benefits package. However, for those who will not, some method of subsidized medical costs with, possibly, a co-payment between the state and the client or among the state, the employer and the client, might be examined. The provision of medical benefits for at least one year after leaving AFDC may be a strong factor in reducing recidivism due to a critical family need for medical coverage.

Family planning services must be funded at a level which allows those already receiving AFDC benefits to regain their self-sufficiency without fear of additional and unplanned pregnancies and for other Texans to avoid becoming dependent. Funding at a level that provides maximum outreach, education and services is a highly cost effective investment for the State.

This system of services--employment, training and education and support services--is the essential element in the restoration of family self-sufficiency and must be designed with care and funded with quality results in mind.

AFDC GRANT

While efforts are underway to provide expanded opportunities to dependent families to attain or regain self-sufficiency, the level at which our poor children are now living must remain a paramount concern. As we have seen, Texas ranks near the bottom of all states in the grant level it now supports, for those families who must depend on AFDC for their survival.

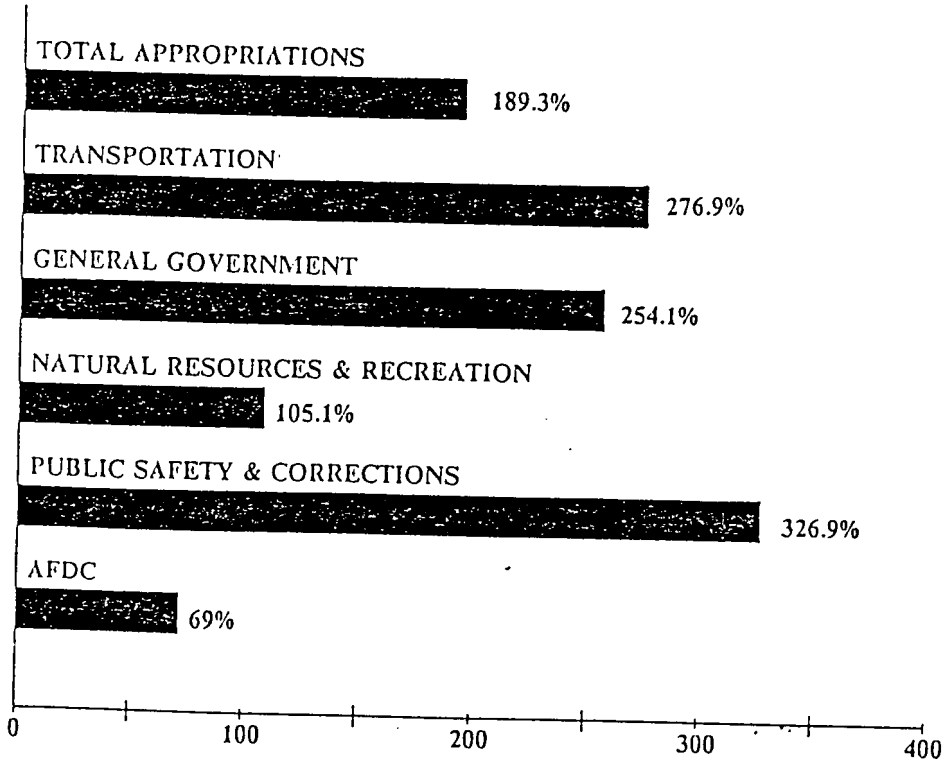
Recent years have seen incremental increases in the AFDC grant level in Texas, increases which have lifted Texas from 49th among the states in grant level in 1980 to 45th today. But expressed in constant 1985 dollars, the value of the AFDC grant in Texas has declined by 58.1% from 1970 to 1985--the most serious erosion of benefits among the 50 states.

In the early eighties, a major state-wide effort was made to draw attention to the AFDC grant levels in Texas and to gain support for their increase. The impetus for this effort was a proposed constitutional amendment to raise the state welfare ceiling. Since 1933, the State Constitution has placed a limit on how many state dollars can be spent on AFDC. That limit has been changed several times over the years and has always been expressed in constant absolute dollars. In 1969 the amount had been set at $80 million. By 1980, due to increases in client population, AFDC expenditures were pushing against this ceiling and without an increase, reductions would have been required.

Rather than again increase the ceiling to a specified dollar amount, it was proposed to set the ceiling at a percentage of the state budget. During the 1981 Session of the Legislature, a Constitutional Amendment was proposed which set the ceiling at one percent of the total state budget. This proposal was placed on the ballot for the November, 1982 General Election. The proposed Amendment enjoyed broad-based, bi-partisan support and editorial endorsement across the state and was approved by a wide margin of the voters. Today, even with recent gains, state spending for AFDC is only about 2/3 of the allowable amount under the state constitution.

The State of Texas is in a serious financial crisis and most of the attention of the Seventieth Session will be directed toward this crisis. Yet the very seriousness of this particular issue and the depth of this problem will require an exhaustive examination of the role of state government and the priorities that the government will set for the future. During more recent and better economic times, assistance for poor children through AFDC actually became a lower state priority than in previous years as is evidenced by the following graph:

PERCENTAGE INCREASE IN FUNDING 1976-77 BIENNIUM TO 1986-87 BIENNIUM



Sources: LBB, Fiscal Size Up, 1986-1987 Biennium, AFDC figures from Appropriations Bills.

As we examine the state's finances and the state's role and priorities, we hope that other members of the Legislature will join us in recognizing that providing at least some measure of basic assistance to children without any other resources is as necessary as maintaing good roads and highways, upgrading public schools and providing public safety. To advocate now, even in these difficult times, for a higher priority for AFDC in the state budget which would reach the one percent constitutional limitation is, in fact, a modest proposal--one that returns to a past level of commitment rather than actually moving forward. Even if we were to reach the current constitutional ceiling, the grant level could not exceed $73 per person or an increase of about $16 a month for each recipient. Even at that level, Texas would still

rank in the bottom ten of the states. If the AFDC-UP option (discussed in the next section) were to be adopted in Texas, this increase would be reduced to a grant of about $65 per recipient.

AFDC-UP

The AFDC option for meeting the needs of Texas children in poverty which the state needs to consider is that of offering AFDC/Medicaid benefits to intact, two-parent families in which the principal wage earner has become unemployed or is underemployed. We know that children in these families suffer the effects of poverty no less than those deprived of parental support for other reasons.

The AFDC Unemployed Parent Program (AFDC-UP) is available, at state option, to families with dependent children who would meet the definition of an AFDC family but for the presence of two able-bodied parents in the home. Establishing eligibility for AFDC-UP, however, involves more than meeting basic income and resource tests. Beyond those basic criteria, AFDC-UP eligibility criteria include:

- the principal wage earner must be unemployed for 30 days
- the principal earner may not have refused a bonaffide offer of employment or training during those 30 days
- the principal earner is unemployed or underemployed under federal criteria and the state's definition of these terms
- the principal earner meets an earnings history requirement

All non-exempt AFDC-UP parents must register for WIN or WIN Demo

Currently, 24 states have AFDC-UP programs. Their experience has been that, on the average, AFDC-UP cases are active for significantly shorter periods of time. A 1981 Missouri study revealed 94.3% of AFDC-UP cases were closed in one year, contrasted with 63.3% of other AFDC cases. (In Texas, 57.3% of AFDC cases are less than one year old.) In Washington State, the average time of dependency of AFDC-UP families was six months. Other experiences have been that AFDC-UP families are equally small in the number of children, but tend to have younger children than other AFDC-assisted families. Over 83% of AFDC-UP families have children under the age of three compared to 46% of AFDC single-parent families. (13)

Poor children in two-parent families have needs as urgent as those in single-parent families but in Texas, they are currently ineligible for assistance unless their families break up. Experience in other states has shown that when they attempted to discontinue AFDC-UP, they saw significant increases in family dissolution with 20-45% of such families then becoming eligible for assistance under regular AFDC rules. These experiences led to several states reinstating AFDC-UP.

Whereas with Texas' low grant level, most families receiving unemployment benefits would not qualify for AFDC-UP unless or until those benefits expired, an AFDC-UP program is especially needed in a state where employment

can often be seasonal, sporadic or part-time. AFDC-UP becomes a supplement to unemployment benefits, ensuring that basic subsistence needs are met, at least for families with young children.

The Texas Department of Human Services estimates that approximately 15,000 families might become eligible for benefits if Texas were to institute the AFDC-UP option. This would add another 12% to the number of families assisted per month. The cost for the State is projected at $20.1 million at a $55.63 per person per month grant level. The benefits, as we have seen, may be in enhancing family integrity and the avoidance of longer-term dependency of a one-parent family unit.

> The costs will be offset significantly, as discussed earlier, because the program discourages family breakup. Families that might otherwise seek regular benefits may be covered as AFDC-UP at little additional cost per month to the state (because of the extra adult recipient in the unit) and less cost per family over time...relatively short case life of AFDC-UP families may mean that maintaining AFDC-UP and averting family breakdown can result in savings in some states. (14)

AFDC-UP would provide vitally needed medical and cash benefits to an additional 34,000 to 36,000 Texas children currently living in poverty. It would increase by 3.3% the proportion of poor children covered by our AFDC program today.

CONCLUSION AND RECOMMENDATIONS:

Regardless of the limitations imposed upon us during difficult budgetary times, we must begin the process of developing a more coherent and effective state policy which will address the issue that is central to the charge of this committee--which is how to alleviate and prevent childhood poverty. In this report, we have focused on how this broad policy objective is currently being addressed through a "system" of programs that have individual goals but which, taken together, contribute to the overall goal articulated in our charge.

As policy makers, the Texas Legislature has considerable latitude in determining the goals of an AFDC program in this state and in achieving these goals through improved coordination and enhancement of current programs as well as through consideration of other program elements that may not yet have been implemented. There is no question that AFDC is a controversial issue, yet at least a general consensus of the objective of the Texas AFDC program will need to be articulated before program components can be considered. Stated in broad terms, any AFDC program should have as its goal the assistance of children in poor families for whom the traditional means of escaping poverty are severely limited, and to do this in a way which encourages self-sufficiency and independence.

In pursuit of this overall goal, a number of strategies must be used in developing a comprehensive AFDC program in Texas. These strategies include:

(1) Pregnancy prevention and early intervention. The increase in unplanned, unwanted pregnancies among young women, particularly teenagers, is the greatest single cause of new additions to the AFDC caseload. Pregnancy prevention is the most cost effective means of reducing the numbers of children in poverty.

(2) Adequate court-ordered child support and effective enforcement. We need to assure that more of the needed income to alleviate poverty among children will come from absent parents who now fail to fulfill their legal obligations to support their children.

(3) Providing employment, education and training opportunities to help families move from poverty to economic independence.

(4) Providing sufficient support services during periods of education and employment training and for those employed at lower wage jobs so that the combination of those wages and those support services will at least meet the combined AFDC benefits of those not working. Such support services can help reduce the economic disincentives that now discourage employment. These support services would include child care, transportation costs, and medical benefits.

(5) Increasing the AFDC grant level. It must finally be recognized that for most families, AFDC is a temporary assistance program. For those families in Texas currently on AFDC, 57.3% have been continuously receiving benefits for less than one year. Improved child support orders and enforcement, employment programs and support services can make the average length of time on AFDC even shorter. In addition, it must be recognized that not all families can achieve economic independence. Caretaker parents are sometimes disabled or have a number of small children to care for or live in areas of high unemployment. For the relatively short period of time that most AFDC families receive benefits and for those families for whom self-support may be impossible, a benefit level that realistically considers the health and well-being of children is essential.

We recognize that the policy goal stated above and the strategies outlined to achieve that goal must be considered as recommendations for a continuing and long-term commitment toward alleviating childhood poverty and helping families become self-sufficient. Yet, even as we struggle with state budgetary problems that make short-term goals more difficult to achieve, the same economic problems which are responsible for declining state revenues are highlighting the increased difficulties that many families face in providing for their children.

Accordingly, there are program components within the strategies outlined that must be advocated even in difficult times. To fail to do so would mean that our long-term goals would rapidly become more costly to achieve. Recognizing our budgetary difficulties, the recommendations which we make are those that are the most cost-effective and will, for the most part, reduce state spending in the short run.

We therefore recommend that family planning funds not only be maintained at current levels but be increased if at all possible. It is likely that because of reduced federal funds it will require additional state dollars to even keep

up. But the proven cost-effectiveness of family planning programs argues for a greater effort. The savings that these dollars return to the state are impressive and do not occur "somewhere down the line," but almost immediately. We must also bear in mind that success in these programs will also eliminate the need for any of the other more costly strategies. We refer also to the recommendations contained in the study on Teenage Pregnancy.

We recommend that child support enforcement be maintained at current levels. Considerable strides have been made in this area in recent years with better enforcement tools and a stronger commitment. It is essential that we continue to press in this area not only for AFDC cases but in all cases in order to prevent possible AFDC dependency in the future. The obligation of all parents to support their children must be stressed as a firm state policy.

We recommend that a Legislative Task Force be created to design a comprehensive employment and training program that will have as its goal the placement of AFDC clients in jobs that will enable families to achieve self-sufficiency above the poverty level. The recommendations of this Task Force shall be presented to the 71st Legislature with the intention of establishing a program during the 1989-91 Biennium. While we would have preferred that such a program be undertaken in the next biennium, the expense that would be required and the greater difficulties that a program would encounter in a time of high unemployment, as well as uncertainty over how a program should be designed for the client population of this state, argues for delay and more detailed study. It is essential, however, that this issue be made one of the highest priority for the state for it is through successful employment that the cycle of poverty is best broken. We must continue to strive for improvement in the programs that we now have and be prepared to respond to changes that may occur at the federal level.

We recommend that child care programs be maintained at current levels. It is of great concern that income eligibles represent the lowest priority for child care services and any reduction of funds for these services would affect those who have achieved a measure of self-support. A significant percentage, perhaps a majority, of those who would lose these services would return to AFDC at an even greater cost to the state.

We finally recommend that sufficient funds be appropriated to the AFDC Program to reach the constitutional limit of one percent of the state budget. The additional funding which this would provide should be used either to raise the average grant per month to around $73 or to adopt the AFDC-UP Program and raise the grant to around $65. While we cannot argue that the approximately $60 million per year funding increase that this would represent would pay immediate dividends in state financing, we again urge the reevaluation of our state priority regarding children. As the Seventieth Legislatue struggles to find permanent solutions to state funding, we urge new sources of revenue be commited to reaching the constitutional limit and making poor children a higher priority in Texas.

NOTES

I. CHILDHOOD POVERTY IN TEXAS

1. Committee on Ways and Means, Unites States House of Representatives. Children in Poverty (WMCP:99-8), Washington, D.C., May, 1985.

2. Randy Washington, for Texas Department of Human Services, in testimony to the Texas House of Representatives Committee on Human Services, November, 1985.

3. Adding a medical benefit value equal to 10% of the poverty level family budget brings this figure to about 58%. See discussion of this medical benefit value in 1978 Income Benefit Study, TDHR, February, 1980, p.32.

4. Children in Poverty, p. 6

5. Data supplied by Texas Department of Human Services, March, 1985.

6. Children's Defense Fund. A Children's Defense Budget: An Analysis of the FY1987 Federal Budget and Children, Washington, D.C., 1986.

7. ibid., p. 140.

8. Weitzman, L. The Divorce Revolution: The Unexpected Social and Economic Consequences for Women and Children in America, New York: The Free Press, 1985.

9. McAdoo, H. and I.M.J. Parham. Services to Young Families, Washington, D.C.: American Public Welfare Association, July, 1985.

10. A Children's Defense Budget, p. 148.

11. Joan Reeves, for Texas Department of Human Services, in testimony to the Texas House of Representatives Committee on Human Services, November, 1985.

12. "Pregnancies Create Trap for Teens," Houston Chronicle, February 23, 1986.

13. Children in Poverty, p. 205.

II. THE SYSTEM OF SERVICES

1. Randy Washington for Texas Department of Human Services, in testimony, November, 1985.

2. Children's Defense Fund. "State Options for Assisting Children in Poverty."

3. Texas Research League Analysis, Vol. 7, No. 3, March, 1986.

4. Crafton, L. Aid to Families with Dependent Children, National and Texas, University of Texas at Austin Center for Social Work Research, August, 1976.

5. ibid., p. 103.

6. Data presented for Texas Department of Human Services to the Texas State Job Training Coordinating Council by Ellen Skinner, February 26, 1986.

7. Independent Evaluation of the Texas Job Training and Work Experience (JTWE) Program, prepared for the Training and Employment Development Division, of the Texas Department of Community Affairs, January, 1985, p. 25.

8. Fortune, June 28, 1982.

9. Reports to the Texas Legislature: Employment Services in the Texas Department of Human Resources and Job Training Work Experience Project (HB1299), TDHR, January, 1985.

10. TDHR Office of Research, Demonstration and Evaluation. Job Search Field Test, TDHR, 1984.

11. Independent Evaluation of the Texas JTWE Program, p. iv.

12. Goldberg, H. Homemaker-Home Health Aide Demonstration: First Year Operational, Texas, Abt and Associates, Inc., August, 1984, under contract with the Texas Department of Human Resources, pp. 66-67.

13. Services to Young Children, p. 107.

14. Oser, M. and D. Schexmayder. Private Sector Employee Benefits in Texas: The Relevance to Working Families, Bureau of Business Research, Graduate School of Business, University of Texas at Austin, November, 1984.

15. Reports to the Texas Legislature: Employment Services in the Texas Department of Human Services . . ., p. 1

16. A Children's Defense Budget, p. 7.

17. Texas Research League Analysis, Vol. 7, No. 3, March, 1986, p. 1.

18. Report to the Joint Select Committee on Fiscal Policy, March 16, 1984, p. III-3.

19. ibid., p. III-4.

20. ibid., p. III-28

21. Report to the Joint Select Committee on Fiscal Policy, Summary, P. 3.

22. Fiscal Size-Up, 1986-1987 Biennium, Legislative Budget Board, p. 83. Note: Under "human Services Programs," the Legislative Budget Board includes the Department of Human Services, the Texas Rehabilitation Commission, the Texas Employment Commission, the Department on Aging, the Commission for the Blind, and the Commission for the Deaf.

III. SOME TEXAS OPTIONS FOR ELIMINATING CHILDHOOD POVERTY

1. Crafton, L. Aid to Families with Dependent Children, National and Texas, p. 103.

2. Texas Department of Health Report #H1006454.

3. United States General Accounting Office, An Overview of the WIN Program: Its Objectives, Accomplishments and Problems, Washington, D.C., June 21, 1982, -. iv.

4. Information about the WEET Program comes from: Petit, M. and L. Wilcox. "Inestimable but Tangible Results in Maine," in Public Welfare, Vol 44, No. 1, Winter, 1986, pp 13-15.

5. "Welfare Cases Drop in Massachusetts." New York Times, November 17, 1985.

6. Atkins, C. "20,000 Choose Paycheck over Welfare Check," Public Welfare, Vol 44, No. 1, Winter, 1986, pp. 20-23.

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9. Texas State Job Training Coordinating Council, Work and Welfare Initiative: A Prospectus, April, 1986.

10. ibid., p. 2

11. This figure is based on $20.2 million state cost for AFDC administration divided by 126,000 average monthly caseload for FY86.

12. National Education Association, 1986.

13. Ebb, N. and C. Lynch. Memorandum: The AFDC-UP Option, The Children's Defense Fund, March 20, 1984.

14. ibid., p. 16.

INTERIM CHARGE: To study the problems encountered by the elderly in gaining access to appropriate post-hospital health care services, including skilled nursing and custodial services.

Appropriate post-hospital care for any patient has always been an important health care issue and even more so for the elderly for whom additional problems are often present. These problems might include the need for skilled nursing care, a period of convalescence, a lack of family members in the home to provide support, and financial ability to pay for needed care and assistance.

For many elderly Americans these problems were considerable eased with the implementation of Medicare in 1966. With hospitalization now covered by a federal insurance program for the elderly, sufficient hospital stays were assured for most older Americans. Under the original payment system doctors and hospitals were in fact encouraged to continue hospital stays. However, this system was soon to be blamed for skyrocketing costs in the Medicare program, costs that threatened to bankrupt the Medicare Trust Fund by 1990. In the first year of the Medicare program, $3.4 billion was spent, but by 1984 the cost had risen to $62.4 billion. As the population of the United States has aged more pressure has been placed on the Medicare system. In 1966, at the beginning of Medicare, only 9.4% of the population was 65 or older. That number grew to 11.6% in 1982 and is expected to increase to 13.1% by the year 2000.

Changes were needed in the system to contain the costs, particularly the costs that are the most expensive - acute hospital care. The United States Congress provided its answer to this problem by the adoption of a revised payment system for Medicare. This is the Diagnosis Related Groups (DRGs) which cap Medicare reimbursements by classifying patients into 468 illness related categories. The reimbursements are based on statistical averages which should adequately compensate hospitals for providing the necessary care. It was expected that while some patients would need to stay longer, others would require a shorter stay and on average the care-givers would be properly reimbursed. Many critics of this system contend that under DRGs the average length of stay has become the maximum stay and hospitals are under strong financial pressure to dismiss patients as early as possible.

As a result of the DRG system the average length of stay for an elderly patient in 1984 was 8.8 days compared to 10.3 days in 1982. [1] While such a reduction was certainly the goal of the change brought about by DRGs, and is often appropriate, the fact is, as many critics have charged, Medicare patients are being discharged "sicker and quicker." As testimony before the subcommittee pointed out, it is apparent that you cannot change one aspect of the health care system without putting pressure on others parts of the system. Such has occurred with the issue of post-hospital care for the elderly. Although this problem has always been a concern, DRGs have impacted the whole system of health care for the elderly and made the issue more critical than ever.

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[1] "Health Care Costs: The Fever Breaks", Business Week, October 21, 1985, pp. 86-94.

It is important to keep in mind that this study is not intended to be a comprehensive review of long-term care for the elderly. That more basic issue has been and will continue to be one of concern. But the issue of post-hospital care for the elderly does impact on the system of long-term care and often the two issues are not easily separated. The shortage of skilled nursing facilities is, for example, a problem of long-term nursing home care, but this problem is also one that is encountered in finding appropriate post-hospital care for the elderly. The earlier dismissals precipitated by DRGs have created a greater demand for skilled nursing facilities and we find that there was already a severe shortage of this care before DRGs. Similarly, home health care and community health care have been expanded in recent years to provide alternatives to nursing home care. Yet two to three times as many chronically ill elderly live in the community rather in nursing homes who are eligible for these types of services. Thus there was already a need for these programs. Meeting these prior needs has made it difficult to readily shift nursing home patients to home care even when home care is appropriate, and now earlier dismissals from hospitals place an even greater demand on this system.

One of the fundamental difficulties in dealing with this problem is the funding of health care for the elderly. The dollars saved by the Medicare system through DRGs may be necessary and appropriate savings, but these are federal dollars while funding for programs to fill the gaps created by earlier dismissals must come in large measure from the states either through Medicaid - which is approximately 50% state funded - or through programs that might be totally state funded. Like many changes in social services in recent years a greater burden has been shifted to the states.

In order to study this issue a subcommittee was appointed consisting of the following members: Representative Mike McKinney - Chairman, Representative Erwin Barton, and Representative Gregory Luna. On March 18, 1986, a public hearing was held in Austin in order to identify the primary issues regarding post-hospital care for the elderly.

The subcommittee first heard testimony on what programs and services currently exist that assist the elderly with post-hospital care. Mary Ann Harvey, administrator with the Texas Department of Human Services, services for the aged and disabled, and Dr. Hilary H. Conner, deputy commissioner for health care services, Texas Department of Human Services, presented testimony regarding current programs. The following is a summary of their testimony supplemented by additional research by committee staff.

Care and assistance available to the elderly falls into two major categories: Institutional Care and Home Care. The outline below summarizes these two categories and breaks them down into specific programs.

I. Institutional Care
  A. Skilled Nursing Facility (SNF)
  B. Intermediate Care Facility (ICF)

II. Home Care
  A. Home Health Care
  B. Community Care Services
    1. Primary Home Care
    2. Family Home Care
    3. Emergency Response Systems (ERS)
    4. Home Delivered Meals

For elderly clients eligibility for institutional or nursing home care is limited to S.S.I recipients or to those who are Medicaid eligible. To qualify for Medicaid a person's maximum income may not exceed $670.20 per month and have maximum resources of over $1700. Those who do qualify for Medicaid nursing home care also receive the full range of Medicaid physician, drug, laboratory, and other services.

Nursing home clients with the most serious medical needs are provided care in Skilled Nursing Facilities (SNFs). There are 11,369 SNF beds contracted for Medicaid, however in fiscal year 1985 only 2,743 Medicaid clients per month received care from SNF facilities. Over $32 million was expended for SNF care in FY 1985. Effective January 1, 1986, the daily rate for SNF care was increased from $41.65 to $44.05. In addition, a supplemental reimbursement of $7.42 per day was approved for certain very heavy care clients.

Most nursing home care is provided in Intermediate Care Facilities (ICFs). During FY 1985, an average of 51,871 clients per month were served at an annual cost of $409 million. The daily rate for ICF level of care is $32.73.

Medicaid eligible nursing home care is funded by both federal and state dollars at an approximate 50/50 match. Total appropriated funds for nursing home vendor payments for FY 1986 is $451,269,187.

Nursing home care is an important part of the range of post-hospital care for the elderly. Approximately 3,000 clients per month enter nursing homes from hospitals either as new admissions or readmissions. For those eligible and needing ICF level care, appropriate care is usually available. For patients with greater needs, skilled care is often unavailable. Nursing homes are not required to accept patients from hospitals that may need a high level of care and often do not do so when they anticipate that the cost of providing care to those patients will exceed their reimbursement under Medicaid. This is clearly one of the most difficult problems encountered in securing appropriate post-hospital care. The change of reimbursement rates for SNF patients and the supplement is a step toward improvement. This issue will be discussed in greater detail later.

For those hospital patients who do not enter a nursing home many receive care at home. The most intensive level of services is provided through home health care. This is a medical program that provides nursing and rehabilitative care for elderly patients. Home health care is designed to serve clients with acute illnesses and can include visits from a registered or licensed nurse, various rehabilitative specialists, and home health aides. Clients eligible for Medicaid must use their Medicare home health benefits before receiving Medicaid benefits. All Medicaid home health benefits are prior approved. Since the majority of these persons are over 65 and Medicaid eligible, Medcaid is the main source for home health care. During FY 1985, a total of 2,669 home health care visits were paid for by Medicaid at a total cost of $1.9 million.

Other home care services are usually referred to as community care services. The two major in-home community care services are Primary Home Care (funded by Medicaid) and Family Care (funded by the Social Services Block Grant). These sevices are designed to support and complement the client's existing family and community support system. Both services can provide a full range of personal care services such as bathing, dressing, meal preparation, grooming, toileting, and assistance with self-administration of medications, if needed. In addition they can provide housekeeping assistance and escort clients to obtain health care. Both Primary Home Care (PHC) and Family Care (FC) are provided through contracts with certified home health agencies.

Primary Home Care services must be authorized by a physician and provided under the supervision of a registered nurse. A maximum of 30 hours per week of care can be provided; however, the average is 12.4 hours. During FY 1985 an average of 20,146 clients per month were served at an annual cost of $70.8 million. Since this is a Medicaid program the cost is shared by the state and federal governments. The Department of Human Services currently pays $5.47 per hour for PHC services. [2]

Family Care services are limited to a maximum of 20 hours per week; however, the average is 8.6 hours per week. During FY 1985, 22,625 clients per month were served at an annual cost of $49.2 million. In January 1986, an additional 676 eligible clients were on waiting lists. Financial eligibility for this program is similar to Medicaid programs except that a client may have maximum resources up to $5,000. The maximum rate the Department pays providers for Family Care is $5.23 per hour. However, due to the use of competitive procurement in contracting for this program, the average rate for FY 1985 is expected to be $4.64 per hour.

Other in-home community care programs provided by the Department of Human Services include Emergency Responses (ERS) and Congregate and Home Delivered Meals (Meals on Wheels). ERS is an electric monitoring service for clients who live alone and permits a quick response in emergencies. A network of volunteers and remote telephone calling capabilities are used to accomplish this. During FY 1985 ERS was provided to 3,346 clients per month at a monthly rate of $16.25 for local phone connections and $21.75 for long distance connections. Meals service was provided to 6,030 clients per month at an average monthly client cost of $53.64. About two-thirds of the ERS and meals clients also receive either Primary Home Care or Family Care.

In addition to in-home community care, there are also out-of-home care arrangements that should be mentioned. Supervised Living and Adult Foster Care provide 24 hour living arrangements for the elderly and disabled who cannot live alone but who do not need nursing home care. Both services provide personal care, protection supervision, housekeeping, transportation/escort, and room and board. Adult Foster Care is provided in the home of the provider while Supervised Living settings serve larger groups of clients. The daily rate paid by DHS for Adult Foster Care is $8.35. The total payment for Supervised Living is a maximum of $21.99 per day. In FY 1985, a monthly average of 521 clients were served by Supervised Living and 468 by Adult Foster Care.

To summarize, Community Care for the Aged and Disabled services were provided to 47,982 clients per month in FY 1985 at an annual cost of $132.2 million. Over 89% of these services were provided by Primary Health Care and Family Care. Community care services are primarily designed to serve clients with chronic health conditions resulting in a high degree of functional impairment. However, many new clients enter the program following hospitalization and most on-going clients have episodes of acute illess that require a hospital stay. Community care services are used for post-hospital care; however, due to the existence of waiting lists in all Social Services Block Grant services and a shortage of funds for Primary Health Care, the availability of community care post-hospital care for new clients is limited.

In addition to the above programs that are funded through the Department of Human Services, there are additional programs funded through the Texas Department on Aging that are of benefit for patients in need of post-hospital

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[2] All rates and hours of services are as of summer 1986 and are subject to change.

care. These are congregate meals and home delivered meals and in-home social services that include homemaker and home health aides. Although these programs offer similar services to those described above under DHS, the funding is primarily federal dollars and the eligibility requirements are less strict. The Texas Department on Aging provides services through twenty-eight area agencies on aging. Funding for the locally administered programs is generally 85% federal, 5% state, and 10% local match. While the types of services are obviously useful for post-hospital care, a shortage of funds and waiting lists often affect the availability of services during the time that patients leaving the hospital need these services the most. Also, federal funds provided through the Older Americans Act of 1965 face cutbacks.

Shortcomings in the system of providing appropriate care specifically targeted at elderly patients being dismissed from the hospital was the subject of further testimony before the subcommittee.

Among the witnesses testifying at the hearing was Ben E. Aguirre, an associate professor of sociology at Texas A&M University. Dr. Aguirre had agreed to assist the subcommittee in this study by conducting a statewide survey on this issue. Dr. Aguirre's contribution was made possible through the assistance of the Texas A&M Public Policy Resources Laboratory. The research that Dr. Aguirre conducted was primarily in the form of a survey of hospital social workers throughout the state. The information obtained through this survey is a significant contribution in our effort to identify the problems encountered by the elderly in seeking post-hospital care. Dr. Aguirre's findings, conclusions, and recommendations were provided to the subcommittee in July, 1986, and are found immediately following this section and should be considered an intergral part of this report. (See Attachment A)

The subcommittee wishes to thank Dr. Aguirre and the Texas A&M Public Policy Resources Laboratory for their professional contribution and kind assistance.

The subcommittee also heard testimony from Elizabeth Clarke, director of social services with Seton Medical Center in Austin and president of the Texas Society for Hospital Social Work Directors. As a discharge planner, Elizabeth Clarke offered an important perspective to the subcommittee as one who works with patients every day to assist them in arranging appropriate post-hospital care. What follows is a general summary of her testimony:

As Ms. Clarke stated in her testimony, it is important to remember that most of the elderly are not in hospitals or nursing homes but reside in the community. No more than 5% of the elderly (over 65) population is actually in a nursing home at any given time. Clarke emphasized that it might be best to consider our institutional care as an adjunct to community care and not the other way around as it is frequently seen.

In reaction to the implementation of DRGs, three major changes were outlined in Clarke's testimony. As she told the subcommittee, a change in any part of the health delivery system will bring changes in other parts, and a change as dramatic as DRGs will have dramatic effects. These three changes are:

(1) A greater emphasis on <u>outpatient treatment</u> rather than hospitalization. Generally this was described as a good thing but it did create problems in patients being able to perform certain follow up procedures that would have been done in the hospital. There are also transportation problems, particularly in a rural area where patients need to return to the hospital on an out patient basis.

(2) The increased use of preadmission testing. Again, for the most part this can be a good thing. Many tests can be done prior to hospitaliztion. But for many patients transportation can again be a problem.

(3) An increased emphasis on discharge planning. Shorter hospital stays are not in themselves a problem. In fact, it is often better to keep the hospital stay as short as possible. But this assumes that the care a patient needs in order to leave the hospital safely will be available in the community. But the changes brought about by DRGs have occurred faster than alternative community services have grown or been put into place to accommodate the new view of the role of the hospital.

In Elizabeth Clarke's view the last change and the failure to adapt other parts of the health care delivery system to meet new needs has resulted in several gaps in an overall system of care. From her perspective as a hospital discharge planner, Clarke lists six major gaps in the system:

(1) The need for transitional programs between acute care hospitals and the permanent needs of the patient. Often patients leaving the hospital need help for only a limited time as they continue to recover and rehabilitate. Whether it is nursing home care or some form of in-home care these services tend to address long-term chronic needs and are not flexible enough to provide a high level of care early in recover and tapering off that level of care as the patient improves.

(2) There is a gap in the payment system for patients in need of nursing home care either temporary or long-term. The thirty day prior institutional rule means that persons will be required to pay for portions of their nursing home bills when they first enter even though they will be eligible for Medicaid. Often these persons have no resources to make this payment. The other gap is the $670.20 a month income cap. Those who have social security and/or pensions higher than that limit are responsible for their entire nursing home payment even though their income often falls well short of the $1,200 to $1,500 a month expense.

(3) There is a gap in providing medication. The Medicare program does not pay for medication outside the hospital. Even those with insurance that will pay 80% of the costs of medicines will find that the remaining 20% can be a considerable expense. Some new antibiotics, although they can be safely administered at home, may cost as much as $100-$200 a day.

(4) Limitations on the Medicare extended care program leave gaps in a program that was intended to provide transitional care. This transitional care program was designed for those who need some limited rehabilitation so that they might be able to return home or at least remain in a nursing home at a lower level of care. However, a patient leaving the hospital who is in need of physical therapy two times a day because of a fractured hip will not necessarily be eligible for an extended care facility under Medicare's payment plan. They must have some complicating medical condition for Medicare to consider them eligible candidates. But if this same patient returns home a maximum of three sessions a week of physical therapy is available. In consequence the rehabilitative needs of the patient may not be met and the person who could be expected to regain full utilization of a hip after surgery may have more limited goals or face a much longer period of recovery.

(5) A lack of trained backup personnel that can work with new technological advancements that would allow a patient to leave acute care settings sooner is a fifth gap. Those systems for home care or even nursing home care are not prepared to provide the level of care which no longer requires treatment in a hospital.

(6) The biggest gap is in the shortage of alternative services. While there is an increased emphasis to utilize fewer days in the hospital there has not been an increase in the number of services available in the community. On the contrary, community services are being cut at the time there they are in even greater demand. Cuts to such ordinary services as Meals on Wheels and the homemaker service run precisely contrary to the need that is perceived from hospitals if we are indeed to reduce health care costs by reducing the number of days a patient stays in the hospital.

Elizabeth Clarke next provided the subcommittee with her suggestions on ways to fill some of these gaps in services:

(1) There is a need for respite care for the caregivers. Most elderly who are in need of care are being cared for at home. They are being cared for by their elderly spouses, or they are being cared for by their children who are themselves in the elderly age group. They are being cared for by children in their middle years who also have teenagers and a full time job to cope with. There is therefore a need for an increase in the type of day care and day rehabilitation programs available for the elderly. Many families need some weekend care so they can get a break. When families are able to get the care they need on an occasional basis they are able to maintain the frail elderly in their home much longer There is also the question of temporary care when the caregiver becomes sick.

(2) Many of the needs are for short-term and temporary services. Short-term 24-hour care in the homemaker service may be needed for a brief period after a hospital stay. Or perhaps a nursing home is needed for a short period as an interim measure before going home. One of the frustrations hospital discharge planners face on a daily basis is to discharge a patient to a nursing home because they do need a fairly high level of care for a period of time. But the planner may know that in six weeks to two months that person could return home if there were someone available to help them make plans and get them into a community care system. At the present time there is no one to whom the discharge planner can make a referral who will follow the patient and make certain that those connections are met.

(3) There is a need for flexibility in the provision of community services. As the length of stay in the hospital declines, we must have access to finding out precisely what services can be made available to this patient on the day of discharge and not wait for an evaluation after the patient is back home.

(4) More specifically, there is a need for an effective case management system for those patients who are referred to community services and who may need a multiple of services for a period of time when they first return home, but for whom those services could gradually be tapered off if there is someone available to monitor them adequately. This is particularly true for those patients who leave the hospital and go into a nursing home for what can be a short term stay but who will need community services in order to return to their home. Several projects nationwide have shown that if patients receive comprehensive case management services for the first six months following discharge, they are less likely to have additional hospitalizations. These persons are more likely to maintain their independence if they receive adequate services when they are needed.

There are obviously many difficulties and concerns regarding appropriate post-hospital care for the elderly. It is a particularly difficult problem because the needs are so varied, ranging from skilled nursing care to a little help at home for the first few days after discharge from the hospital. The

problem for state policy makers is that decisions made at the federal level are placing strains on the health care system that are adversely affecting post-hospital care delivery. The change to DRG reimbursements is the most notable change. At the same time overall federal cutbacks on programs that were already in place have resulted in fewer services being available when most needed. The state can, of course, replace federal cuts with state dollars, but the federal funds are being cut back in many ares such as family planning, child abuse prevention, and child care. Given the limited state dollars that we have during the current budget crunch and the need to address so many important issues, it will be difficult to replace federal funds in all areas of need at current levels.

We do urge the federal government to explore options within the Medicare program to guarantee that Medicare patients receive the hospital care they need. It is encouraging that in response to many complaints the federal government is now requiring hospitals to inform patients covered by Medicare that they have a legal right to challenge their discharge if they think they are being sent home prematurely.

There are areas where the state can adopt policy and program changes that can improve access to post-hospital care. In the critical area of the availability of skilled nursing home care there is no question that the level of Medicaid reimbursement in Texas for this level of care has drastically limited the number of skilled nursing beds and left nursing homes with little or no incentive to accept patients leaving the hospital who require a high level of care, even if this need will be only for a limited time.

Recognizing this need the Board of the Texas Department of Human Services adopted on January 24, 1986, an increase in SNF reimbursement from $41.65 a day to $44.05 a day. DHS staff hopes that this 5.76% increase will help alleviate some of the access problems elderly patients face as they are discharged from the hospital but require skilled nursing care. In addition, a supplementary reimbursement of $7.42 a day above the regular SNF rate was approved for those patients requiring a heavy level of care and attention.[3]

While these two actions should somewhat improve access, even a $51.47 a day reimbursement to nursing homes (1986 SNF rate + supplement) will not adequately cover many post-hospital care patients with intense skilled nursing needs. It will require an evaluation after several months at the 1986 rates to determine what effect these rates will have on access to skilled nursing facilitites.

Meanwhile a more comprehensive answer to adequate reimbursement is currently being studied by DHS. It has long been felt that the basic two-tiered system of reimbursement (ICF and SNF) cannot adequately provide the levels of reimbursement necessary to cover a wide range of services needed by the elderly in nursing homes, not only for long-term care but for shorter term post-hospital care.

The alternative, one that has been instituted in some other states, is called case mix. At the March 18 public hearing, the subcommittee heard testimony from Robert Conkright, who had formerly worked on the case mix concept as an employee of DHS and who is now a consultant with the Texas Health Care Association.

In his testimony Mr. Conkright reported that there are currently (January 1986) approximately 11,500 SNF beds, a slight decrease from the 13,000 in 1980, though this decrease could accelerate due to a DHS rule that 25% of al skilled nursing beds must be Medicaid certified.

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[3] A rollback of the supplementary add-on was proposed by the LBB as a Level III budget reduction on the eve of the Special Session.

Regardless of what impact this rule might have on the number of SNF beds in the future, it is know already that although the number of SNF beds has remained fairly constant, the number of skilled patients had fallen from 8,000 in 1980 to 3,700 in 1986 - and 900 of those are in ICF beds.

To explain how it is that with a declining SNF caseload and an excess of beds that skilled needs patients are having trouble finding SNF care, Conkright referred to a study he worked on in 1983 while with DHS.

In that study (called PRISE) it was shown that the hardest to care for group of patients comprised 10-12% of the skilled population. Today that category is one-third of the SNF population. The second hardest to care for group made up 25-30% of the skilled population in 1981 and today that percentage is 72%. In addition, today 15% of the intermediate care population falls into the second hardest to care for category. If these individuals were reclassified as skilled needs patients, the SNF population would increase from 3,700 to around 10,000.

At the same time, as Mr. Conkright testified, hospitals are reporting that they have patients will skilled level of care needs that cost they up to $500 a day. Even with the increased SNF reimbursement and the supplement ($51.47 a day) nursing homes find it difficult to accept such patients. The problem in not finding a skilled nursing bed for a patient leaving the hospital and needing such care is not usually a shortage of SNF beds, there are SNF beds not being used, but an inability of Medicaid to reimburse nursing homes for patients requiring levels of care significantly higher than $51.47 a day.

The current DHS study is called the Long-Term Care Case Mix Reimbursement Project. Basically case mix would provide a number of reimbursement levels based on an assessment of patient characteristics and patient needs. Providing a wider range of reimbursement levels would reduce the likelihood of under-reimbursement or over-reimbursement. Under a system based on case mix the economic disincentives that lead to problems of access and low quality could be reduced. A more complete description of this project is to be found at the end of this report. (See Attachment B)

The Long-Term Case Mix Reimbursement Project is complex but is being vigorously pursued. This subcommittee supports this effort, and while it may not be a panacea for either the problem of post-hospital care or long-term care. it can be hoped that a cost-effective reimbursement plan will have a positive impact on the availability of higher levels of care for the post-hospital elderly patient.

While the problem of access to skilled nursing home care for the elderly is tied to changes in the federal Medicare program and in state methods for Medicaid reimbursement, the problem of appropriate home care following a hospital stay is more often a result of difficulty in gaining timely access to a dwindling supply of affordable or subsidized services.

All the home care programs that have been previously discussed are in short supply and often in danger of further cutbacks. These problems affect all the elderly who are in need of and eligible for these services. For the patient facing discharge from a hospital the problem is more acute for that patient is in need of immediate help and waiting lists or delays prevent assistance from being available when it is most needed. It is important for these patients to receive an assessment of their needs prior to discharge from the hospital so that the needed services can be in place when the patient reaches home. For that to occur requires a case management system, a system that not only will perform the needed assessment but will follow the patient's changing needs and make changes as circumstances warrant. Often these changes can save money because

as a patient recovers more expensive care can be ended in favor of more modest and less expensive care. Without monitoring expensive care is sometimes continued beyond the time it is actually needed.

Hospital social services can perform part of this function, particularly the in-hospital assessment and arranging for appropriate care upon discharge. The extent that hospital personnel perform this function varies widely throughout the state and from hospital to hospital. But even where there is a good hospital program that works with the patient, the ability of hospital discharge planners to follow the patient after a suitable post-hospital placement is limited. For example, a discharge planner working for a hospital may place a patient in a skilled nursing facility and assist in all the necessary paperwork in doing this. But the patient may need skilled care in a nursing home for only a few weeks and other arrangements then become appropriate. By that time the hospital discharge planner will no longer be involved with the patient. What is needed is a case management system that follows the patient from the hospital all the way through recovery and has the ability to adjust the level of care for the patient as required.

While DHS has the authority to do case management they do not have the staff necessary to adequately carry out this function. But a demonstration project funded in part through DHS and a private foundation is showing how such a case management system could make maximum use out of limited services while working with the patient to gain access to the most appropriate and least restrictive level of care.

The Mary E. Bivins Foundation of Amarillo in conjunction with the Department of Human Services has established a project called the Alternative Care Team for the Elderly (ACT). The main objective of this pilot project is to help elderly persons recover from acute medical crises such as strokes or fractures and allow them to return to their homes as quickly as possible. The focus is to help the elderly hospital patient avoid going into a nursing home upon discharge if at all possible, or if a nursing home is needed for short time to move that patient out of the nursing home as soon a
To so this the ACT caseworkers rely on a wide range of services as alternatives to nursing home care.

The ACT program is a Medicaid eligible program but a recent grant from the Texas Department on Aging to the Panhandle Area Agency on Aging has supplemented this project to allow expansion of the ACT project to serve the near-poor and middle economic segments of the population. A system of copayment and sliding scale fees based on ability to pay is being developed for this part of the program. The program is also designed to provide preventative and rehabilitative services to those impaired elderly who are not quite sick enough to meet the ACT medical eligibility criteria.

The ACT project with the additional services that can now be offered through the Department on Aging grant represents a positive response to the critical problem of providing the most appropriate post-hospital care for the elderly. We hope that in evaluating this program both the Department of Human Services and the Department on Aging will consider the benefits in Human terms of such a program. We realize that a case management approach can be costly in terms of staff and, while there may be some offsetting costs as less expensive arrangements are substituted for nursing home care, the costs overall may be higher. But providing this kind of assistance to our elderly population may be crucial to the quality of life that they can achieve following an acute medical crises. Attachment C to this report is a description of the ACT program. The eligibility criteria discussed in this description applies to the DHS funded part of the project. The portion that is funded through the Department on Aging will be different.

Two other issues which were raised at the March 18 public hearing are the subjects of two other detailed studies being conducted elsewhere. One of these is the issue of Alzheimer's Disease. This problem is an interim study of the Senate Committee on Health and Human Resources. This study will address the long term needs of persons with Alzheimer's Disease and the private and public resources available to address these needs.

In addition, the entire issue of third-party reimbursement or insurance coverage for long-term care needs is being pursued by the State Board of Insurance. During the last legislative session, S.C.R. 123 was passed directing this study. According to the resolution long-term care is defined not only as nursing home care but as "home care and community based care which provides personal care and assistance in activities of daily living, such as homemaker, home health, day activity and health services."

Both of these studies will be completed before January 1987 and will be available to the 70th Legislature. They will both have important implications for the issue of post-hospital care for the elderly.

ATTACHMENT A

THE POST-HOSPITAL CARE NEEDS OF THE ELDERLY IN TEXAS

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THE POST-HOSPITAL CARE NEEDS OF THE ELDERLY IN TEXAS

The objective of this study is to outline the problems faced by elderly patients throughout Texas in obtaining appropriate post-hospital care, using information provided by professionals involved in hospital discharge planning. Our interest is justified on three grounds. First, following the national trend, the aged in Texas account for an increasing proportion of the population of the state: 1 in every 10 Texans in 1980 was 65 years of age and older, or in excess of 1,500,000 people. Second, on a per capita basis the aged population is the greatest consumer of health care services. Third, the emphasis today is on outpatient treatment and rehabilitation rather than on long-term hospitalization. This means that the post-hospital care needs of the elderly have increased. The health delivery system is in a period of transition and readjustment, and this affects elderly patients in various ways. It is the intent of this study to shed light on these effects.

The paper is divided into three parts. The first section presents the procedures used in the study. This is followed by the presentation of the findings, in three subsections. The first describes the post-hospital care needs of elderly patients going home from the hospital. The second describes the problems faced by elderly patients needing to go to nursing homes. The final subsection of the findings presents a comparative analysis of all of these problems, ranking them in terms of their relative perceived seriousness. It shows that the problems can be ordered, and that the resulting scale is reliable. The third and final part of the paper presents

a summary highlighting the most significant findings of the research and offering some suggestions to the Committee.

METHODS

We surveyed hospital directors of social work throughout the state of Texas during April through June 1986. Following procedures established by Dillman (1978), questionnaires were mailed to all the members of the Texas Society of Hospital Social Work Directors (TSHSWD). For those not responding, Dillman's total design method was supplemented with telephone calls to the presumed places of employment to ascertain the respondents' statuses. In all, we mailed questionnaires to 186 directors working in hospitals in 78 cities throughout Texas. Of these, 28 directors no longer worked at the hospitals listed and had not left forwarding addresses, three were excluded because they worked in psychiatric and children's hospitals which did not treat elderly patients, and one director refused to answer the questionnaire even after four attempts to encourage her participation. 154 directors returned useable questionnaires. In some of these cases we telephoned the respondents to increase the completeness of the information they had provided in the questionnaires. This is the information presented in this report.

The respondents are highly skilled and experienced, including 27 bachelors of social work, 101 masters (M.S.W.) and five doctorates (D.S.W.). Only 17 directors did not hold some level of social work certification from the Texas Department of Human Services (TDHS). The rest were certified by TDHS, including 49 C.S.W. - A.C.P. (Certified Social Worker - Advanced Clinical Practitioner), 58 C.S.W. (Certified Social Worker), and 20 S.W. (Social Worker). Seventy-six percent of the directors had been social workers 7 or more years. Seventy-two percent currently spend 50 or more percent of their work time helping elderly patients. In sum, they are

eminently qualified to evaluate the post-hospital health care needs of elderly patients in Texas.

The questionnaire contains 38 questions, mostly closed-ended multiple-choice format (copy available upon request), which were developed from in-depth interviews with two current hospital directors of social work who functioned as key informants, and from Elizabeth Clarke's (1986) written expert testimony to the Subcommittee of The Texas House of Representatives Health and Human Service Committee.

FINDINGS

GOING HOME

Home Assistance

When an elderly patient is going home from the hospital and needs in-home assistance care, he or she faces difficulties in arranging for this care. If the patient can meet both the medical and financial criteria for the Primary Care Program of the Texas Department of Human Services (TDHS) he or she may receive up to 30 hours per week of personal care (bathing, cooking, light housekeeping) from a home maker (provider). This is a good program but in many places throughout the state it cannot be planned for during the hospital stay and arranged to begin on the date of the person's discharge. Fifty percent of the respondents answered that at the present time in their community they can not plan for TDHS's Primary Home Care Program while the elderly patients are in the hospital so that services would begin at the time of discharge, and 46 percent of these respondents agreed that not being able to begin these services at the time of the elderly patients' discharge is very frequently a serious problem. Similarly, certification for TDHS's Family Care Program cannot be planned during the patient's hospital stay. Instead, elderly patients are evaluated by TDHS case workers in their homes, and several days pass before home care

services begin. This delay of service was seen by 61 percent of the respondents as a very frequent serious problem.

A change in TDHS policy to allow evaluation of the elderly patients while they are in the hospital is needed to remedy this problem.

Meals

Another issue for the elderly person returning home from the hospital who could function fairly well with some assistance in preparing meals, is that meals on wheels programs may not exist in their communities, or there may be waiting periods, or difficulty in finding volunteers to deliver the meals. Most elderly persons who qualify for TDHS's Meals-on-Wheels Program are on Medicaid. Elderly persons on Medicaid who had no need for this service prior to hospitalization oftentime cannot receive this service immediately after discharge. Eighty-seven respondents had sufficient information to give an estimate of the average waiting period in their communities for elderly patients to be certified by TDHS's Meals-on-Wheel Program: 48 percent calculated that it took a week or less, 23 percent thought that it took between one and two weeks, and 29 percent estimated that the waiting period was longer than two weeks.

In some communities the same type of meals service is provided by private or public local agencies, although oftentimes the recipients are asked for a contribution and volunteers are needed to deliver the meals. 77 respondents reported that there are these meals-on-wheel programs in their communities, and 69 of these respondents had sufficient information about these local programs to estimate the average waiting period for elderly persons to participate in them; 48 percent (of these 69 respondents) calculated that it took an average of less than three days to begin receiving these services, 28 percent thought that it took between 3 to 7 days, and 24 percent estimated that the waiting period was longer than one

week.

The apparent differences in the estimated effectiveness of the various meals-on-wheel service delivery systems is striking. Future research is needed to look in depth into the validity of these estimates and the advisability of either eliminating TDHS's Meals-on-Wheel Program and reinvesting the public funds thus saved in the local and voluntary meals-on-wheel programs or of improving the quality and responsiveness of this TDHS program.

Medication

Elderly patients who are living on social security benefits and have Medicare sometimes may not take their prescribed medication after leaving the hospital because Medicare does not cover the cost of their prescription medicine while they are at home. For some patients this cost sometimes amounts to over one-fourth of their social security pension. While Medicaid covers 3 prescriptions per month, this is insufficient for elderly persons who are on more than 3 medications. Fifty-seven percent of the respondents (N=149) state that the cost of uncovered outpatient medication is very frequently a serious problem for elderly patients. Apparently there is widespread ignorance among the respondents of the ways in which medical prescriptions can be ordered by medical doctors <u>in tandem</u> in the Medicaid program so as to alleviate this problem. Perhaps their professional association (TSHSWD) could be used to disseminate this information among them.

Medical Equipment

Another problem centers on the rental of medical equipment to be used at home. Persons who are on Medicare can usually manage this cost as Medicare pays for 80% of the rental charge. However, Medicaid does not cover durable medical equipment. This situation often means that the poorest elderly

patients are unable to secure hospital beds, wheel chairs and other equipment to use in their homes. Seventy-six percent of the respondents (N=151) answer that for Medicaid patients having to pay for the rental of durable equipment to be used at home is very frequently a serious problem.

This is the highest level of concern expressed for an item included in this survey. The Legislature of the State needs to reassess the state involvement in the Medicaid Program, with the primary intent of evaluating the feasibility of remedying this important deficiency in the health care system.

Therapy at Home

There are also difficulties with home-health nursing care. Both Medicare and Medicaid provide for visiting nursing services, but there are some limitations. Broadly speaking, we can think of two categories of nursing care. In the first category there is a skilled service provided by a nurse and which allows the monitoring of the patient's health status. In this category of nursing care Medicaid specifies a limit of 50 visits per calendar year. Medicare patients leaving the hospital who are in need of physical therapy will not necessarily be eligible for an extended care facility under Medicare's payment plan, for they must have some complicating medical condition for Medicare to consider them eligible. If these patients return home, the maximum amount of physical therapy available under Medicare home health program is three times per week. Twenty-nine percent of the respondents (N=149) agreed that obtaining adequate rehabilitation under Medicare is a very serious problem.

The second category of nursing services centers on educating the elderly patients or their family caregivers. In this type of service the expectation is that the patient or his caregiver will have mastered the skill in a short period of time, usually two weeks. Yet, perhaps a longer

period of time is needed. The problem is that sometimes it takes the patient or the caregiver longer than the stipulated time to learn and be comfortable with performing the health service independent of nurses' supervision. Some elderly people need somebody continuously to supervise the taking of their medication.

In this connection 46 percent of the respondents (N=151) state that obtaining, for elderly patients leaving the hospital, 24-hour medical supervision at home for a week or two is very frequently a serious problem.

Income Difficulties

Another difficulty faced by elderly persons who are close to qualifying for supplementary security income (SSI-Medicaid) is that their medical expenses such as doctor bills and medication are not taken into consideration when determining their eligibility for SSI-Medicaid, and many of them are disqualified.

An important problem for the "young elderly" persons (those under 65) who are on social security disability (SS-disability) is that they do not become eligible for Medicare until they have been on SS-disability for 2 years. Unfortunately, most of these persons also do not qualify for Supplementary Security Income (SSI-Medicaid) because their social security disability pension is larger than the income limits for SSI. For example, a person whose only income is $400 a month in SS-disability is left without any medical or hospital coverage or benefits for two years. This is particularly illogical, for if a patient is able to qualify for SS-disability, he or she is going to have significant medical care expenses, and therefore it is unreasonable that these same people have to wait for 2 years for Medicare coverage.

A troublesome situation is that of elderly patients with meager financial resources who are nevertheless above the maximum monthly income

level set to qualify them for Medicaid nursing home care benefits. In their case, they will not be able to go to a nursing home unless their relatives can afford to pay for it. Elderly patients' monthly income may be large enough to make them ineligible to qualify for the nursing home Medicaid program but not large enough to pay privately for a nursing home. Fifty-two percent of the respondents (N=151) agree that this issue of marginal income very frequently is a serious problem in arranging payment for nursing home placement.

Another factor that places the "young elderly" person in financial difficulties is that the application procedures for SS or SSI disability are quite lengthy. During this waiting period these persons may be totally without income. One hundred-sixteen respondents had sufficient information on the operation of these two programs in their communities to estimate the number of days, on average, which elapse before certification. Eighty-one percent of these respondents stated that certification for SS-Disability took 60 days or more. The corresponding figure for SSI-Disability is 77 percent. In sum, the norm in both programs is a waiting period in excess of two months.

Refusing to Go

Another complex problem is that an elderly person without adequate in-home care and with severe disability (i.e., bedridden) can refuse nursing home placement. In these cases, even with the involvement of TDHS's adult protective service workers, placement in a nursing home can occur only if the person can be determined to be legally incompetent and a guardian appointed. This determination of incompetence is difficult to establish, for usually the person is competent but reluctant to relinguish independent living or is fearful of going to live in a nursing home. Thirty-nine percent of the respondents (N=150) agree that this refusal to accept nursing

home services very frequently is a serious problem. In this connection, 21 percent of the respondents (N=150) stated that the lack of counseling of families of elderly persons is a very serious problem.

A difficulty faced by elderly patients in need of services is obtaining and completing applications for various programs unassisted. Forty-one percent of the respondents (N=151) stated that this is very frequently a serious problem.

Applying to Programs

Inability to apply for various programs is caused in part by the elderly's lack of transportation. Transportation difficulties, however, also affect the elderly patients' ability to obtain outpatient care, rehabilitation, preadmission testing, and post-surgery treatment. Surprisingly, in spite of the ubiguitous effects of transportation difficulties only 39 percent of the respondents (N=150) stated that the lack of transportation for elderly patients is very frequently a serious problem.

Need for a Case Management System

There is a consensus among the respondents that a case management system is needed. In this system an agency would be responsible for informing the elderly of community resources available to them, assisting the elderly in obtaining appropriate services, and maintaining ongoing contact and follow-up to determine that the level of service is appropriate. Seventy percent of the respondents (N=149) strongly agreed with the statement that a case management system is needed. Moreover, 48 percent (N=149) strongly agreed that some elderly patients in nursing homes could return home if an agency was available to help them make plans and to get them into a community care system. In essence these responses indicate widespread agreement on the need for integrating and rationalizing available community services for the elderly. It appears that the need is not only for more programs but also

for better use of available programs.

Other Community Resources

Given the fact that at any moment in time most of the elderly population is not institutionalized, but resides in the community, we asked the respondents to report on their community resources in geriatric day care programs, day rehabilitation programs and weekend care programs. These are three family support systems which facilitate the elderly patients' ability to reside in their homes or in the homes of family members. Thirty-seven percent of the respondents (N=143) lived in communities without geriatric day care programs, 42 percent lived in communities with one or two, and the rest lived in communities with more than two geriatric day care programs. Only 71 respondents had information about the operation of these geriatric day care centers, and 76 percent reported that there were no waiting periods to enroll in them.

Sixty-four percent of the respondents (N=137) lived in communities without day rehabilitation programs for elderly persons. Only 35 respondents knew about the operation of these rehabilitation centers, and 77 percent reported that there were no waiting periods to enroll in them.

Finally, 80 percent of the respondents (N=138) lived in communities without weekend care programs for elderly persons. Only 22 respondents knew about the operation of these weekend care programs, and 91 percent reported that there were no waiting periods to enroll in them.

In short, while geriatric day care programs are fairly well established throughout Texas, this is not the case for geriatric day rehabilitation and weekend care programs. Tax breaks and other available public policy instruments need to be used to induce and encourage private enterprise in this area.

GOING TO A NURSING HOME

Prepayment

Persons going to a nursing home from the hospital are going to pay for this care through Medicare, Medicaid, private insurance, or their own resources. Those with limited financial resources probably will seek Medicaid coverage of the basic nursing home care cost. All persons seeking this assistance, even if they are already on Medicaid, must apply for the Medicaid nursing home benefit program.

Until very recently federal directives had established that if 50% or more of the person's care in the hospital was being covered by Medicare or some other private insurance, the person, when transferred to a nursing home, was responsible for at least the first month of nursing home care even if he or she otherwise met the medical and financial criteria for Medicaid coverage. While this regulation is no longer in force, nursing homes continue to require elderly patients to prepay the first month of care. Seventy-seven percent of the respondents (N=130) stated that 50 percent or more of the nursing homes in their communities required this first month admission prepayment. Moreover, 54 percent of the respondents (N=149) mentioned that this prepayment requirement very frequently is a serious problem for elderly persons.

Another problem is that if Medicaid will be the source of payment, nursing homes are now requiring that the elderly person pays his or her per diem prorated share of his SSI monthly benefit for the month the person enters the nursing home. The problem is that oftentimes by the time of the month the patient enters the nursing home he or she would have spent his SSI monthly income and would not have the money available. Fifty-three percent of the respondents (N=148) agreed that having to pay portions of months of nursing home care is very frequently a serious problem for elderly persons.

Elderly persons in nursing home with Medicaid benefits are required to use their income minus $25 allowance for incidental expenses, to pay part of the cost of the basic nursing home care, which is then supplemented by Medicaid. This fact causes a number of important difficulties: a) An individual who has been living alone in the community, and whose nursing home stay is anticipated to be short-term, losses the ability to maintain a private residence because he or she has insufficient discretionary funds to pay for it. Thus, when the elderly person no longer meets the medical criteria for Medicaid nursing home placement, he or she has no home to go to and no resources to draw upon to establish a new one. b) For elderly couples in which one spouse is entering the nursing home and the other spouse remains in their home, the aforementioned requirement often means that the remaining spouse has insufficient resources to pay living expenses. In these situations, spouses have refused to go into nursing homes because of the economic hardship it would cause on their spouse. However, in doing this problems occur, for oftentimes the other spouse is either incapable of providing the needed care or ruins his or her own health trying to do so. c) While Medicaid covers the basic costs of nursing home care, there are certain things it will not cover. Two important costs which are not covered is the cost of any prescription over 3 prescriptions per month and oxygen if it is needed. However, the patient only has $25 a month of discretionary income. The end result of this is either that the $25 allowance is used to pay for these costs, or that the relatives are asked to defray them, or that the patient goes into debt, so that after he or she leaves the nursing home the patient must pay this bill.

Thirty-five percent of the respondents (N=150) agree that, for elderly patients, having to pay for oxygen is very frequently a serious problem. Indeed, 48 percent (N=149) state that nursing homes in their communities are

denying admissions to elderly patients if they do not agree to pay for the oxygen.

Skilled Care

Some people argue that there is a shortage of skilled nursing home beds. At times elderly persons must wait in the hospital for a bed in a skilled nursing home. Sixty-nine percent of the respondents (N=150) strongly agree that at the present time there is a scarcity of skilled nursing home beds in their communities. However, only 33 percent (N=151) state that obtaining skilled nursing home care in their communities is very frequently a serious problem, or mentioned that it was very difficult to get elderly patients certified for skilled nursing home care in their communities. In this vein, 48 percent (N=132) estimated that, on average, it took a week or less for elderly patients to be certified by Medicaid for skilled nursing home care in their communities, not an unreasonably long delay, it would seem.

Presumably, a problem which has come about as a result of the recent Medicare's Diagnosis Related Group (DGR) procedure for paying hospital care is that on average hospital stays are shorter and patients are being transferred to nursing homes with greater health care needs. This would mean that it is more costly to the nursing homes to provide the care, and thus, that they would sometimes refuse to accept patients who have these treatment needs; this in turn is also presumed to be a primary cause of the scarcity of skilled nursing home beds. Only a minority of the respondents (41 percent, N=150), however, strongly agreed that patients are being discharged with greater health care needs since DGR took effect. Similarly, only 48 percent (N=150) strongly agreed that the nursing homes in their communities may be unable in the future to meet the increased demand (both in term of volume and quality of care) for services created by DGR.

The previous pages have presented a detailed item-by-item review of the

opinions of the respondents about the problems faced by elderly persons in gaining access to post-hospital health care. In the concluding section of this report we turn to a comparison of the relative importance of each of these problems of the elderly.

Comparing the Problems

The respondents, while recognizing the seriousness of the problems included in this report, nevertheless were able meaningfully to differentiate among them. Thus, some problems, such as the absence of a case management system or the renting of durable equipment, received very high rankings in terms of their perceived seriousness. Other problems, such as the absence of counseling for the families of the elderly, did not. Table 1 reintroduces the relative ranking of 18 problems discussed earlier, including the proportion of respondents who ranked them as "very serious" or "very frequently serious." It should be mentioned that the problems constitute a reliable scale (Nunnally, 1967:226). The standardized item alpha for the resulting 18 items scale is .79. In short, not only are the problems ranked on the aggregate, but each individual respondent also tended to replicate this ranking in his or her pattern of responses.

Table 1

Relative Ranking of Eighteen Problems

Lack of counseling of families	.23*
Rehabilitation under Medicare	.29
Obtaining skilled nursing home care	.33
Payment of oxygen	.35
Lack of transportation	.37
Refusal to accept nursing home services	.39
Applying for various programs unassisted	.40
Nursing homes unable to meet increased demand	.41
Medical supervision at home	.48
Need someone to act as mediator	.48
Marginal income	.50
Payment of portions of months of nursing home care	.51
Payment of first month of nursing home care	.53
Uncovered outpatient medication	.55
Delay of home care services	.61
Need for a case management system	.68
Scarcity of skilled nursing home beds	.69
Rental of durable equipment	.74

*Proportion of 142 respondents agreeing that it is a "very serious," or that it is "very frequently a serious" problem

CONCLUSION

Some of the pitfalls in federal programs documented in this report can not be corrected at the state level. Nevertheless, there is still considerable room for bringing about improvement in the conditions of the elderly in the state. I would like to conclude this report by listing some of the options open to the state, options which do not involve the expenditure of large sums of public funds.

1. The Committee should conduct a thorough investigation of TDHS's Primary Care Programs and Family Care Programs, to ascertain the feasability of allowing certification to take place while the elderly are in the hospital.

2. The Committee should look into the operation of TDHS's Meals-on-Wheels Program, to ascertain ways of improving its effectiveness and responsiveness, and to consider alternative means of delivering this service.

3. The Committee should ask state agencies to disseminate among social workers and other caregivers throughout the state, on an ongoing basis, information as to how to use most effectively available state and federal programs serving the elderly. For example, during the March 18th subcommittee public hearing in Austin, Texas, TDHS officials informed the subcommittee that there is a way for medical doctors to order prescriptions in Medicaid in tandem to get around the program limit of 3 prescriptions per month. Yet, I have documented that this information is not widely known, and that this problem is seen as a quite serious problem by a majority of the respondents. More broadly, there is a need for the dissemination of information on changes in these programs, so as to increase the efficiency and affectiveness of social workers and other care providers.

4. The Committee should explore the possible ways in which a case management system could be implemented. For it is obvious that some agency, perhaps an agency of the state, needs to take over the job of coordinating the health services already available to the aged.

5. The Legislature should consider ways of encouraging the growth of private sector involvement in the provision of services for the elderly, especially geriatric day care, weekend care, and day rehabilitation programs.

6. The Committee should investigate the admission criteria used by nursing homes throughout the state, and the legality of existing practices in denying admission or in demanding advanced payment from the elderly.

7. The Committee should look into the state involvement with Medicaid and the feasibility of including the rental of durable medical equipment and the payment of oxygen as approved benefits.

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ATTACHMENT B

A Description of the Nursing Home Case Mix Reimbursement Project
(prepared by the Texas Department of Human Services)

THE NURSING HOME CASE MIX REIMBURSEMENT PROJECT

SUMMARY

The Texas Department of Human Services (DHS) has undertaken the Long-Term Care Case Mix Reimbursement Project to develop a more refined prospective reimbursement system in Texas based on case mix. Because reimbursement based on case mix is designed to foster cost containment, good patient access, and quality of care, it appears as an attractive alternative to other systems. Reimbursement based on case mix involves objective assessment of the patient characteristics associated with various patterns of service needs, the determination of average service need, and reimbursement at a rate appropriate to that average need. When a system based on case mix is sensitive enough to a range of variation in patient characteristics that influence costs of service, there is reduced likelihood of under-reimbursement and over-reimbursement. Under a system based on case mix, the economic incentives leading to problems of access and low quality are minimized. The development of a more refined, prospective, case mix reimbursement system in Texas could begin to resolve the problems associated with reimbursement on the basis of overly simplified level-of-care distinctions.

OVERVIEW OF GOALS AND OBJECTIVES

The overall goal of the project is to develop a reimbursement methodology based on case mix for long-term care facilities in Texas. The methodology will reflect, as accurately as is feasible, institutional case mix and associated costs of service and should result in more equitable payments to providers than the current uniform flat rate offers. Implementation of the methodology should contain costs while restructuring financial incentives to allow for improved access and quality of care.

Important components of the project include development of a valid and reliable patient assessment instrument; extensive study of case mix indices and methodologies in other states; application of several different case mix indices to Texas assessment data; study of the relationship among the different case mix indices; and simulation of the effects of using different case mix indices in a long-term care reimbursement system.

The intermediate objectives of the Case Mix Project may be summarized as follows:

1. Develop a patient assessment instrument that could be used in a reimbursement system based on case mix, establish the validity of instrument, and establish the correspondence of this case mix assessment instrument and the existing level-of-care instrument in order to allow historical and longitudinal analyses.

2. Study case mix research and implementations in other states, choose indices for study with Texas data, and select one of these case mix indices upon which to base a new prospective reimbursement methodology.

3. Develop a case mix reimbursement methodology that would encourage (a) cost containment, (b) quality care, and (c) access to appropriate care (the methodology would incorporate monitoring and incentive mechanisms found to be effective in other states).

4. Plan a demonstration project in nursing homes to test whether better patient access, better matching of patients to resources, better quality of care, equitable reimbursement, and cost containment do in fact result from the new reimbursement methodology.

RESEARCH DESIGN, METHODOLOGY AND IMPLEMENTATION

The Case Mix Reimbursement Project was designed to be a multi-year research effort. Over the next year, the project will be collecting and analyzing patient-related data from a sample of 53 Texas nursing homes. Two types of data will be collected: (1) assessment data relative to the functional limitations and service needs of individual patients, and (2) data on staff time devoted to the care of that patient (resource utilization). Two cycles of data collection are planned. The first will begin in January 1986; the second in June 1986.

The project has recently completed work on a preliminary patient assessment instrument for the first cycle of data collection. The Client Assessment and Research Evaluation (C.A.R.E.) instrument includes approximately 80 items in five major categories: (1) general medical evaluation, (2) activities of daily living, (3) psychosocial and behavioral condition, (4) services and treatments, and (5) comments for special patient cases.

In developing the C.A.R.E. instrument, the project studied the patient assessment instruments from six other states and selected the patient descriptors and scales most appropriate for inclusion. A nurse consultant was hired to assist project staff with this task. A ten-member work group of medical professionals and others knowledgeable about patient assessment techniques is currently reviewing the draft instrument.

The project has also designed special forms to collect data on the amount of staff time devoted to the care of the individual patients. All RNs, LVNs and Aides on the wings selected for inclusion in the study will be required to provide an estimate of the amount of time spent with individual patients during their shift. The time estimates provided by facility staff will be used to measure each patient's direct care resource utilization.

The first cycle of data collection will begin January 13, 1986. A nurse from each of the fifty-three (53) nursing homes will be trained by project staff on the procedures for completing the C.A.R.E. instrument. In addition, each nursing home will appoint one person to be trained as the Time Study Coordinator. This person will be trained to coordinate and monitor the Staff Time Measurement Study.

Following the first cycle of data collection, the C.A.R.E. information will be analyzed for inconsistencies and further validation and refinement of the instrument. A second complete cycle of data collection will serve to validate the revised C.A.R.E. instrument.

Utilizing the data from the second cycle of data collection, the Case Mix Project will develop a case mix index that is related to the resource utilization by patients and to the cost of providing care. This task will involve (1) study of the case mix indices from other states, (2) selection of case mix indices for a detailed study of the relationship between these case mix indices and patient resource consumption, (3) study of the relationship between these case mix indices and cost of care, (4) determination of the reaction of health care experts and the nursing home industry to the case mix indices, and (5) selection of the most advantageous case mix index. A prospective reimbursement system will be designed around the selected case mix index.

The final task of the project will to plan a demonstration of the new reimbursement system in a sample of Texas nursing homes. This planning will include (1) modifying state rules to allow the demonstration, (2) developing an appropriate sampling scheme to choose facilities for inclusion in the demonstration, and (3) obtaining industry compliance with the demonstration. The demonstration project will be planned during the third project year, 1987, for potential implementation during fiscal year 1988.

ATTACHMENT C

A Description of the Alternative Care Team for the Elderly Project (ACT)

ACT for the Elderly

Alternate Care Team

A Project of the Mary E. Bivins Foundation

To Prospective ACT Clients and Their Families:

The persons who just visited and left (or sent) you this information packet are members of the ACT for the Elderly project. ACT (Alternate Care Team) is a unique program sponsored jointly in Potter and Randall counties by the Texas Department of Human Services (TDHS) and the Mary E. Bivins Foundation. Our job is to help people avoid going into nursing homes before they really need to.

One of ACT's main purposes is to make sure that elderly persons who are thinking about going to a nursing home are well informed about the decision they and their families are about to make. There are many alternatives to nursing home care available today--services designed to lighten the burden of care in the home. Often they can make it possible for elderly people to remain at home, or to return home after only a brief stay in the hospital or nursing home. Many of them are available at no cost to qualifying individuals. We have contacted you to make sure you know about these services. If you wish to consider them, we will help you determine which of them you are eligible for, and see that you get the combination best suited to your needs.

Another of ACT's important priorities is rehabilitation--restoring function, getting people back on their feet. Time after time we have watched the work performed by physical, speech, or occupational therapists make it possible for elderly people to regain abilities they thought they had lost--even after a serious setback like a stroke or fracture. It is no exaggeration to say that rehabilitation therapy--and a suitable exercise program after therapy--often determines the quality of the rest of the person's life. But it needs to start early enough. We think that every person who has suffered recent impairment of his or her physical abilities should be carefully assessed for rehabilitation potential, and should have the opportunity to receive therapy if it is appropriate. Working with your physician, ACT will set this process in motion for you, even if you are not interested in the other alternate care services we can arrange. Rehabilitation therapy is generally available at no cost to homebound or nursing home patients through Medicare.

Part of the attached information packet is a list of the services available locally as alternatives to nursing home care. It is worth studying. Several of them are free to ACT clients, as well as to others who meet certain financial and other requirements. ACT's eligibility

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requirements are explained on another page, also part of the packet. We've also included a guide to TDHS's financial eligibility categories. We'll be happy to answer any questions you might have about this material after you've had a chance to look it over.

If you decide to apply for ACT program services, simply sign and date the back of the application form (the last page of this packet) and return it to us, and we will continue the assessment and eligibility determination procedure we began in our initial visit. Another copy of the application agreement is included in this packet in case you need to refer to it later (see the page headed "Explanation of Rights, Responsibilities, Consent and Certification").

If you don't qualify for ACT services, you may nonetheless be eligible for TDHS's normal program of in-home services, or for nursing home placement under the TDHS Medicaid program. We'll send you a letter explaining why your application for ACT program services had to be turned down, and if you like, we'll help you find out whether you are eligible for the TDHS in-home or nursing home programs. You are free to reapply for ACT program services whenever your eligibility situation changes.

If you do qualify for the ACT program, we will begin working with your physician and others involved in your care to draw up a plan of services based on your needs and wishes. As an ACT client, you are a member of the team of persons making decisions about your care. For this reason, you will be asked to sign this plan and any revisions to it. You will always have the right to choose between the services listed in the plan and nursing home care. In addition, you can refuse any service at any time and you can leave the program whenever you wish.

When all members of your care team have agreed to the services shown in the service plan and have signed it, you become an ACT client. We will arrange for your services to begin as soon as possible. Our nurse and social worker will visit you at least once a month to check on your progress and to see that your services are appropriate to your needs. Feel free to let them know of your concerns, either during their visits or by calling our office between visits. We're here to assist you. Remember that as an ACT client you pay nothing for the in-home services you receive through our program.

When it comes time for you to leave the program, we

will notify you in advance and transfer your case to another agency if you need further services. We will not discharge you as long as you meet ACT's eligibility requirements and are in need of services available only through the program. Generally, we discharge clients when their condition has improved so much they no longer need the services we provide, or when it becomes apparent that their condition is not likely to respond to further application of services, or when they no longer meet the program's eligibility requirements. After discharge we will contact you periodically to see how you are doing. If you need further assistance and are eligible, you can be readmitted.

I urge you to consider the alternatives presented by the ACT program. We will do everything we can to put you in touch with the services you need to get you comfortably back on your feet and back home. Please call me personally if you have further questions I can answer about the ACT program or about other services to the elderly in Potter and Randall counties.

Sincerely,

Gordon Darrow

Gordon Darrow
Program Director
(806) 359-1611

ACT for the Elderly

Alternate Care Team
A Project of the Mary E. Bivins Foundation

Alternatives to Nursing Home Care Available to the Elderly in Potter and Randall Counties

Many elderly persons need assistance with their care but are not yet ready to enter a nursing home. There are several services available in the Amarillo/Canyon area designed to help older people keep living independently. Call the ACT for the Elderly office for details:

Basic Care Services

*1. 24-Hour Home Care: Persons coming home from the hospital often need 24-hour supervision for a period of time. This program provides continuous coverage by an aide, either physically present or on call through the emergency response system (see below). Two weeks maximum. Available only to certain ACT clients.

*2. Primary Home Care and Family Care (two separate programs): An aide comes to your home to help with non-medical tasks such as bathing, dressing, grooming, light housekeeping, cooking, shopping, etc. Up to 30 hours a week, depending on need (20-hour maximum for Family Care).

*3. Home Health Aide: In-home visits by an aide to help with specific personal care tasks such as bathing, grooming, dressing, food preparation, etc. The aide stays only as long as needed to complete the tasks. A Medicare program.

*4. Skilled Nursing Visits: In-home visits by a licensed nurse to perform specific medical tasks such as blood pressure monitoring, dressing care, administration of medications, etc. A Medicare program.

5. Private Duty Nurse, Aide, or Sitter: In-home care by a nurse, aide, or sitter; hours as needed. Private pay only.

*6. Adult Day Care: Supervised care and activities at the Jan Werner Adult Day Care Center between the hours of 7:30 a.m. and 5:30 p.m., Monday through Friday. Full or half-day schedule available, up to five days a week. Supervision by licensed nurses, meals, physical therapy program. If necessary, participants can arrange to be picked up and brought home in lift-equipped vans.

*7. Respite Care: Up to 24 hours a day supervised residential care at Jan Werner Adult Day Care Center (16 days maximum). Provides relief to family caregivers for weekends, vacations, illness and emergencies. Semi-private bedrooms, assistance with personal care, meals, use of the Center's other facilities and programs.

*Available at no cost to qualifying individuals.

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*8. Supervised Living and Foster Care (two separate programs): 24-hour supervision in a residential facility or foster home. Clients must be ambulatory and able to provide most of their own care.

Rehabilitative Services

9. Temporary Nursing Home Stay: If you are recovering from an illness or are in need of rehabilitation services or medical stabilization, you can enter a nursing home for a short stay to facilitate recuperation. Nursing home care under Medicaid requires evidence of medical need, determined by assessment.

*10. Rehabilitative Therapy: Physical, speech, respiratory or occupational therapy administered by a licensed therapist, either to homebound individuals or to inpatients in nursing homes. Physician's orders required.

Other Support Services

*11. Emergency Response System (Lifeline): Provides immediate 24-hour access to emergency services at the press of a button. Each subscriber has a communicator unit connected to his telephone and a portable button which can be worn on clothing or carried around the house in a pocket. Pressing the button signals a dispatch operator, who sends assistance. The system also automatically signals for help when the person fails to reset a timing device once a day. Available throughout the Panhandle.

*12. Operation Contact: A volunteer contacts you by telephone every day to be sure you are all right.

*13. Home-Delivered Meals: Two programs in Amarillo deliver a hot, well-balanced meal to persons 60 or older who are homebound and unable to prepare their own meals: Meals on Wheels and ASCA Silver Service. Some special diets are available.

14. Congregate Meals: A hot, well-balanced noon meal is served daily to persons 60 or older at eight locations in Amarillo and Canyon. Spouses, regardless of age, are also eligible. Contribution requested.

*15. Urban Transportation Service: Transportation in lift-equipped vans to the doctor, druggist, senior citizens center, congregate meal sites, grocery, beauty shop, etc. 24-hour notice required.

16. Rent Subsidy Program: Rental assistance to help low income individuals obtain housing. (This program has very restricted availability.)

*17. Minor Home Modifications: Removal of minor barriers to mobility in the home by installing ramps, widening doors, installing grab bars in bathrooms, etc. Available only to certain ACT clients.

*Available at no cost to qualifying individuals.

ACT for the Elderly

Admission Criteria

To admit a client, we have to have a "yes" to each of the following questions:

1. Age 65 or older?

2. Resident of Potter or Randall counties, or planning to move to a Potter/Randall address?

3. Financially eligible? (Any one of the following will establish financial eligibility:)

   (a) SSI recipient?
   (b) Medicaid number?
   (c) Individual income less than $670.20 per month and resources (savings, CDs, certain types of insurance, etc.) less than $1,700?

4. ICF or SNF level of care assignable? (This means the client has medical needs of such a nature that he or she would be eligible for placement in a nursing home under the Medicaid program.)

5. Rehabilitation potential? (This means a physician's order for therapy, and a therapist's assessment of need for therapy.)

6. Does the attending physician approve of the patient's entry into the ACT program?

7. Does the client (and family) want the program?

Once a client is admitted, the services provided by the ACT program are available at no charge.

ACT services include primary home care, family care, adult day care, respite care, supervised living, foster care, rehabilitation therapy, skilled nursing and home health aide visits, and the emergency response system. In addition, ACT clients who are recipients of Supplemental Security Income (SSI) may also be eligible for home-delivered meals, 24-hour home care, and minor home modifications.

A GUIDE TO FINANCIAL ELIGIBILITY

Your eligibility to receive many publicly supported services depends on your financial status. This is true of the Medicaid and Title XX services for the elderly offered in our area by the Texas Department of Human Services (TDHS) and the ACT for the Elderly program. Here is a guide to the financial limits used to determine eligibility for these services. (The services themselves are described elsewhere in this packet.)

CAUTION: The eligibility limits presented in this guide are approximate and subject to change. Always consult the ACT for the Elderly staff or a TDHS caseworker before proceeding with a decision. Also, bear in mind that many of the services require evidence of medical need as well as of financial eligibility.

Definitions:

"Total monthly income" means the sum of income you receive regularly each month (monthly social security and SSI checks, pensions, disability payments, annuities, royalties and mineral rights payments, etc.).

"Countable resources" means the sum of your assets, except the value of your homestead, but including savings, C.D.s, stocks and bonds, cash value of insurance policies, and other property.

Eligibility Categories:

1. If your total monthly income is less than $356, and your total countable resources do not exceed $1,700, you may be eligible to receive Supplemental Security Income (SSI) from Social Security. Subject to medical need, SSI recipients are eligible for all Medicaid and other TDHS benefits, including hospital care, prescription drugs (up to three prescriptions per month), nursing home care*, day care, respite care, supervised living, foster home care, and primary home care. SSI recipients are also eligible for all services offered through the ACT for the Elderly program. To apply for SSI, contact the Social Security Administration office (in Amarillo, 3601 W. 15th, 376-2241).

2. If your monthly income is less than $670.20 and your countable resources do not exceed $1,700, you may be eligible for nursing home care* under the Medicaid program, depending on medical need.

3. If your total monthly income is less than $670.20, and your countable resources amount to less than $5,000, you may be eligible for day care, respite care, supervised living, foster home care, and family care (an in-home service). These are all Title XX services available only through TDHS.

*You may be asked to pay part of the cost of this service.

INTERIM CHARGE: To study the Child Protective Services Program of the Department of Human Services regarding case workloads and staffing requirements.

One of the gravest responsibilities granted by the people of Texas to their state government is the protection of children from abuse and neglect. A growing awareness of the incidence of child abuse and neglect, and a better understanding of the cyclical nature of abuse and the long-term impact abuse has on society has made the public more insistant that stronger efforts be made to protect children from harm. To that end state laws have been enacted which seek to combat this growing problem. Among the significant state laws that address the need to protect children are:

(1) Section 34.01, Texas Family Code, requires all persons to report cases of suspected child abuse or neglect.

(2) Section 34.02, Texas Family Code, specifies that the Texas Department of Human Services shall be the agency responsible for receiving reports of suspected abuse and neglect and that the Department is required to notify the appropriate state or local law enforcement agency of the report.

(3) Section 34.05, Texas Family Code, requires the Texas Department of Human Services to investigate the reports of abuse and neglect that it receives and specifies what that investigation shall determine and what the investigation shall or may include. This section further requires investigators to petition for immediate removal of a child from the home if it is found that this is necessary to protect the child from further abuse and neglect.

(4) Sections 17.01, 17.02, 17.03, Texas Family Code, establishes procedures by which the representative of the Texas Department of Human Services, as well as a law enforcement officer or juvenile probation officer, may take possession of a child in an emergency.

(5) Chapter 41, Texas Human Resources Code, names the Texas Department of Human Services as the state agency generally responsible for child welfare and protective services and authorizes payments for protective foster care.

In addition to state statute, protective services for children are authorized by Title IV-B of the Social Security Act, 42 USCA 620 et. seq., and the Child Abuse Prevention and Treatment Act, (P.L. 93-247), 42 USCA 5101 et seq., 45 CFR Part 1355.

To comply with these statutory mandates and carry out the responsibilites assigned to it, the Texas Department of Human Services has established the Child Protective Services Program. Administratively, this program is a part of Protective Services to Families and Children which also includes foster care assistance payments, an alternative treatment for youth program, truant and runaway services, and family violence services, as well as child protective services.

During fiscal year 1985, 2,552 full-time employees were assigned to the Protective Services for Abused and Neglected Families and Children Program and all but a few of these employees are in Child Protective Services. The other programs are either pass through payments without employees - as with the Foster Care Assistance payments - or are largely contracted out. Unlike many DHS programs which are either pass through payments or are contracted, the Child Protective Service Program is mainly a direct service program. The sensitivity and complex legal nature of child abuse and neglect cases make contracted services undesirable if not unworkable. Although some continuing services are contracted out or referred to community agencies, Department staff, located in local offices around the state, are responsible for receiving and investigating reports of child abuse and neglect and taking action necessary to protect children from further harm, including the placing of children in temporary or permanent substitute homes. Even when some client services are provided through contract, Child Protective Services personnel remain responsible for monitoring the case until the objectives of the services are met and the case is closed.

Last session the Legislature increased funding for Child Protective Services. This increase, coming at a time of restrained growth in state spending, reflected a recognition that during the past several years the program had not been able to keep pace with an alarming increase in reports of child abuse and neglect, that, in fact, the number of child protective services workers had declined while both reports and need for services were increasing. The increased appropriations demonstrated an intent to increase the number of protective services staff for investigation of reports of child abuse and neglect and to provide staff and contracted services for follow-up efforts. Total budgeted amounts for the Child Protective Serives Program over the past three years are as follows:

Program Area Program Component	1984 Expended	1985 Estimated	1986 Budgeted
02 Child Protective Services:			
Salary	47,310,459	50,802,939	56,931,815
Travel	3,502,923	3,852,054	4,088,553
Overhead	7,159,476	9,911,243	12,251,038
Client Services	10,715,599	9,829,165	12,386,207
Activity Total	68,688,457	74,395,401	85,657,613

Overall, FY 1986 budgeted amounts for Child Protective Services represent a 15% increase over FY 1985. It is of some concern that the salary component increased 12% while the overhead component increased 23.6%. While we recognize that expenses for those items identified as overhead (office supplies and equipment, telephone, postage, building rent, etc.) have increased overall and do increase with additional staff, it is regrettable that a greater percentage of the increase could not have been budgeted for salaries which would have provided some additional caseworkers.

Nevertheless, budget increases over the past three years have enabled the Department of Human Services to increase staff for this program with the emphasis being placed on direct delivery workers. The following is a summary of Child Protective Services staffing over the past three years:

CHILD PROTECTIVE SERVICES STAFF, FY 1984 - 1986

STAFF	FY 1984	FY 1985*	FY 1986**
Direct Delivery:			
Workers	1,286	1,321	1,405
Case Aides	83.5	102	100
Total Direct	1,369.5	1,423	1,505
Administration & Support:			
Program Directors	46	44	44
Supervisors	204	211	225
Admin./Technical	130	138	138
Clerical/Other	750.5	730	683
Total Admin. & Support	1,130.5	1,123	1,090
TOTAL ACTIVITY	2,500	2,546	2,595

* Actual Staff

** Estimated staff
Does not include regional matrix generic support staff previously staffed in protective services in FY 1984 and FY 1985. FY 1986 is based on FY 1988/1989 LAR; FY 1984 & FY 1985 are based on FY 1986 Operating Plan.

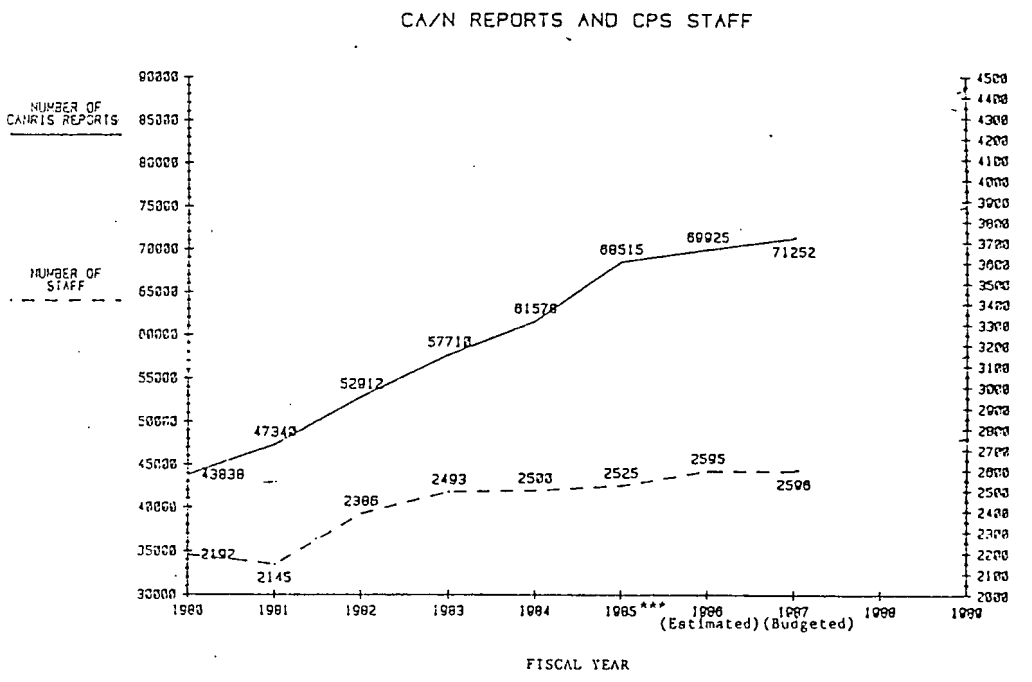
Despite these staffing increases there remain serious concerns about the ability of the program to respond appropriately and as mandated in child abuse and neglect cases. Adequate staffing is necessary not only to insure a timely investigation to prevent additional harm to a child, but to provide continuing services that will enable a resolution of the case to be achieved that will be in the best interest of the child.

Central to this concern about staffing levels is the fact that, despite the slight turnaround in the last two or three years, the past decade has seen a general decline in the number of child protective services staff. This decline is seen both in the actual numbers of personnel and, more severely, in relation to the increased number of reports of child abuse and neglect. This staffing and workload pattern is illustrated by the graph on the following page.

The graph does not show that in the years just before 1980, that staffing had declined to the extent that current levels for Protective Services are approximately those of 1977. As the number of staff has remained basically static during the last decade while the number of reported cases of child abuse and neglect has nearly doubled over the same period of time, the protective services program has felt increased pressure to meet its statutory mandate to investigate all reports of child abuse and neglect.

This increased pressure has been experienced primarily by front-line child protective services workers. In 1980, the average caseload of a child protective services worker in Texas was 40. In order to get a perspective on the importance of controlling caseload we refer to a report by the American Humane Association:

> Controlling caseload is critical if effective child protective services are to be provided. No matter how proficient the CPS worker is, if his or her caseload is overly large, the



> worker is relegated to the position of case manager. To deliver effective treatment services to abusing and neglecting families there must be a policy limiting caseload size, and it must be enforced....
> It is disturbing that so many states fail to recognize the importance and difficulty of performing the CPS function that they do not realistically control demands placed on workers. These results lead inevitable to a questioning of whether the uniqueness and value of CPS are properly perceived at the state level and whether there is adequate commitment to this uniqueness so that caseload size is limited to a more realistic level. [1]

This report further states that, "The most widely accepted standard for caseload size is 20 to 25 cases (families) per protective worker." [2]

While it is clear that increases in the staffing levels of child protective services workers will have a positive impact on caseloads and in turn on the ability of each individual worker to deliver needed services and comply with statutory mandates, there are alternate methods to mangage the increasing numbers of reports of child abuse and neglect which must be considered.

For the purpose of this report we have identified two main areas for review which can effectively improve the state's ability to protect children who are victims of abuse and neglect with limited staff while controlling caseloads.

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[1] The American Humane Association, "Child Protective Services Entering the 1980's" (Englewood, Colorado, 1979), p. 6.

[2] ibid., p. 7.

First, we can work to improve the skill and professionalism of staff, providing them with the ability to manage cases in the most effective and efficient manner possible. A more highly skilled staff will not only be able to handle cases more efficiently, but the children and families in need of services will be helped as well. Second, a clear definition of what constitutes child abuse and/or neglect is needed, as well as a clear understanding of the role of the state and the role of the child protective services worker.

Issues that relate to the first area of concern are staff training and staff turnover. The entry level child protective services worker is classified as a Child Protective Services Worker I at state pay group 12. For fiscal year 1986, this pay group received a salary of $19,404 per year at entry level. The only qualification for this position is a bachelor's degree from an accredited college or university. The Child Protective Services Worker II position, which can also be entry level, requires a more advanced or more specialized degree or a basic college degree with experience in the field.

These front-line positions require the ability to handle a complex variety of situations often under great stress. The worker is responsible for many critical decisions that will greatly influence the lives of children. The worker must assess the urgency of a report and must decide whether or not emergency action is needed to remove a child from a home. The worker will develop a case plan, arrange for foster or adoptive care, arrange medical, educational, and/or psychiatric treatment for a child in need of services, work with families with in-home services, and be called upon to offer expert testimony in court. The job, in short, is highly complex and sensitive, and requries both training and experience to be perormed successfully.

In April 1982, the Department of Human Services initiated Basic Job Skills Training (BJST) for child protective services workers. An evaluation of this training program indicated that it was successful in meeting standards such that participants could deliver basic child protective services.

In order to provide more advanced and continuing training a Managed Staff Development Model (MSDM) was developed in May 1983 for a planned sequence of competency based programmatic training. Under this model the basic program was considered to be the initial phase of training.

For fiscal years 1985/1986 the Department is developing a federally funded Advanced Job Skills Training Program (AJST). The Basic Job Skills Training was revised in September 1985 to be consistent with the advanced program. The basic program includes an orientation and both classroom and on-the-job training experiences to prepare new workers for the demanding task of child protective services.

The effort undertaken by DHS to improve worker skills through professional programs is essential and, at the same time, points up the related problem of staff turnover.

Turnover has always been a problem in protective services, not only in Texas but nationally. Stress, long hours, and low pay result in "burn out." It is a difficult job and the rewards are all too few. But as we invest more time and energy in training staff to perform effectively it becomes even more important to retain experienced professionals. A trained, experienced, and highly motivated professional staff can do more toward meeting the needs of children at risk than can newer and less experienced staff even if there are more of the latter. The skill of knowing which cases require immediate attention and which are less important can save time and more effectively manage the caseload. The ability to utilize community resources and to network volunteer and other programs can

do much not only to improve the efficiency of staff but to provide the best assistance for children and families. Such ability comes with experience and just as it is important to consider the number of child protective service workers it is also important to pursue policies that will retain those who are experienced.

In 1978, one DHS region showed that of its child protective services workers 36.1% had 0-12 months of experience and 77.8% had 0-36 months experience. State-wide in 1979, the turnover rate for child protective services workers was 32.3%. It declined considerable the next year due largely to the severe economic recession. Since that time the turnover rate has remained below 20%, although it must be emphasized that by any standard the turnover is still high and remains a problem because of high replacement costs, the disruption of case plans, the overloading of the remaining staff who have to take over cases for those who leave the job, the demoralizing of staff, a general slow down of the program's operations, and a general adverse affect on clients.

The table below indicates turnover rates in the most recent years broken down by staff position:

CHILD PROTECTIVE SERVICES STAFF
ANNUAL TURNOVER RATES

	Administrative	Worker	Clerical
FY 1980	11.39	19.06	26.79
FY 1982	10.90	19.24	17.31
FY 1984	6.92	16.44	10.98
FY 1985	6.49	17.01	12.97
FY 1986*	6.14	16.44	13.14

* FY 1986 figures are projected from 9 months of data.

One factor that contributed to a decline in turnover in FY 1984 was an upgrading of child protective services worker positions. These were increased one pay grade as a result of action during the 1983 legislative session. There was clearly a need for an overall salary increase for these workers and to recognize as well the level of professionalism that is needed for this job. Also, an additional position has been created one grade above that of Child Protective Services Specialist II. This is the Human Services Specialist and this position provides something of a career ladder for highly experienced and skilled workers who wish to remain in direct case work. Previously the only option available to an experienced worker who wished to advance was to move into a supervisory position. These skilled professionals are used for more difficult cases and provide guidance and training models for less experienced personnel. Use of this position to retain experienced workers has been limited due to overall shortage of funds.

Other changes that have helped in reducing turnover (some of these are agency-wide changes) include the use of flex-time, and a workload management system, which we will discuss later.

While measures have been taken to reduce turnover, the rate still remains high. In order to retain experienced and dedicated workers it is important not only to take steps that will reward individuals and control their caseload but to assure that the overall responsibility of the state to protect children is being met. Caseworkers often express concern that they are unable to do as much as they in their professional judgement believe is needed. Case workers feel that more workers are needed to both reduce their individual burdens and to assure that the needs of children are being met. Concern over unmet needs is a primary cause of worker stress and burnout, often most affecting those workers with the highest personal standards of professionalism and deepest concern for children.

Methods of controlling caseloads have been implemented in recent years that raise the issue of what is to be defined as child abuse and neglect and how limited resources can best be utilized to address critical needs. Although the Texas Family Code requires investigations of all reports of child abuse and neglect, there are no specific definitions of what constitutes child abuse and neglect. Such definitions and clear guidelines for when intervention is appropriate will obviously affect caseloads and the ability of child protective services workers to focus time and energy on the most demanding cases.

In 1979, DHS implemented a priority system for investigating reports alleging child abuse and/or neglect. Such reports are grouped into one of three categories as follows:

> Priority I - all reports indicating immediate danger or life threatening circumstances for a child, including severe injuries (fractures, burns, internal injuries), children under age six with any injuries that appear to be from abuse, sexual abuse of children under the age of 12, and neglect that indicates immediate danger such as failure to thrive children, or pre-schoolers without any adult supervision or community support.
>
> Priority II - all other reports of abuse and/or neglect of children including bruises of school age children, non-life threatening neglect of children of any age and sexual abuse of children age 12 or above.
>
> Priority III - all other reports not containing allegations of abuse and/or neglect or immediate harm to children, but which include indications of dynamics of abuse and/or neglect which could result in abuse and/or neglect in the future.

The priority policy contains time frames for the Department's response to reports and for notification to law enforcement. These time frames are as follows:

> Priority I - face-to-face interview/observation of the child or children and oral notification to law enforcement within 24 hours of DHS' receipt of the report.
>
> Priority II - face-to-face interview/observation of the child or children and oral or written notification to law enforcement within 10 days of DHS' receipt of the report.

Sexual Abuse Reports - regardless of the report's priority, there is oral notification to law enforcement within 24 hours of DHS' receipt of the report.

Priority III - investigation only occurs when staff and community resources allow. Volunteers may conduct all or part of a Priority III investigation.

This priority system has been both successful and controversial. Successful in the sense that workloads are eased as workers are not required to conduct investigations when the report does not indicate that actual abuse or neglect has occurred, but controversial in the sense that many uninvestigated reports might be more serious than the report indicates or intervention could prevent future abuse from occurring.

There is a need to more clearly define child abuse and neglect in statute so that our policy on this issue can be addressed in law by the Legislature as it is now being addressed by the budget process. At the present time levels of appropriations require the agency to define child abuse and neglect with consideration to how much can be done within the allotted resources. For example, in 1981, due mainly to federal budget cuts, services for runaways, truants, and unmarried school age parents were moved from Priority II to Priority III.

One recent article discusses the issue of definitions of child abuse and points out that these definitions, or lack of definitions, tend to cause both excessive and inadequate intervention.[3] When laws are vague and definitions unclear overintervention can occur. Not only does this undermine the overall public confidence in child protective services and risk excessive intrusion into private family matters, but it overburdens caseworkers with less significant cases at the expense of more critical ones.

We need to consider carefully what our expectations are for child protective services and make those expectations a clear state policy. That policy should then be pursued both through statute and in budget levels. As the article states:

> The role of law should be to establish reasonable expectations about what can - and what cannot - be done to protect children. Only in this way will law be able to guide and limit intervention.[4]

This issue is being studied elsewhere. It is a legislative initiative of DHS and is being reviewed in the sunset process. The House Select Committee on Child Abuse is also studying the need for statutory definitions. The issue is somewhat beyond the scope of this report but changes in the law and a clear legislatively established policy can have important ramifications regarding case workloads and staffing requirements.

Meanwhile the Department of Human Services has sought to improve both case workloads and productivity through the Child Welfare Productivity Improvement Project (CWPIP). One of the major recommendations of CWPIP was the workload management system which became state-wide policy in 1984. This program provides

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[3] see Douglas J. Besharov, "Right Versus Rights, The Dilemma of Child Protection," Public Welfare, Spring 1985, pp. 19-27.

[4] ibid. p. 24.

an effective ceiling on caseload size and provides a structure to prevent workers from getting too far behind on their caseloads. Workload management has resulted in smaller caseloads.

Other outcomes of the Child Welfare Productivity Improvement Project include the use of Quality Circles and a Records Management System. Quality Circles are small groups of staff who do similar work meeting regularly to systematically identify, analyze, and propose solutions in their area of expertise. The Records Management System consists of a number of time-management innovations and improvement of office skills.

As stated earlier in this report, the average caseload per child protective services worker in Texas in 1980 was 40, and at least one article states that a widely accepted standard for caseloads size is 20 to 25. In 1986, the average caseload per child protective services worker in Texas had been reduced to 29.

It is important to remember that this reduction has been achieved exclusively through DHS initiated changes discussed above, such as prioritization and institution of a workload management system. There has not been any significant increase in staff to deal with the increasing number of reports of child abuse. Two concerns come to mind. One, the current caseload, though smaller, will contain almost exclusively difficult and troublesome cases since lower priority cases have already been weeded out. Second, these lower priority cases which are not usually even defined as child abuse are nevertheless often cases of real concern and are often situations where there is a high probability of future child abuse or neglect. Often these cases could benefit from intervention that would help the whole family, yet state resources are rarely available. Tragically these cases may in time become a Priority I or II.

In regard to this second issue we will take note of the use of volunteers in assisting child abuse and neglect workers, particularly in Priority III cases. There are a number and variety of volunteer programs across the state that are successfully augmenting the efforts of state workers in combating and preventing child abuse. These include:

Family Outreach of America - The Family Outreach Program deals primarily with what are or would be considered Priority III cases. The purpose of the program is to prevent child abuse and neglect by offering services to children and parents in families where there is a demonstrated potential for abuse and/or neglect. All services, including home visits, are provided by trained volunteers under the supervision of a DHS caseworker. In addition to working directly with families, Family Outreach volunteers teach parenting classes and deliver presentations to the community concerning the problems of abuse and neglect.

Parents Anonymous of Texas - All Parents Anonymous services are provided cost-free to parents and children through a state-wide volunteer network. Volunteers work in conjunction with DHS staff to provide services to families in which abuse and/or neglect has occurred or in which the risk of such exists. Services include parent support groups, programs for children, and a state-wide helpline.

Texas Coalition for the Prevention of Child Abuse - The goal of this program is to establish a state-wide network of child abuse/neglect prevention services so that all families and children have access to comprehensive support systems. TCPCA is again co-sponsoring, with DHS and the Governor's Office, the Governor's Conference on Prevention of Child Abuse which will be held in Austin in September. TCPCA encourages the development of community coalitions to prevent child abuse/neglect.

Big Brothers/Big Sisters - This program pairs adult volunteers with children, usually from single parent families, in order to provide the child with a positive role model who can offer one-on-one attention and support.

Court Appointed Special Advocates - These trained volunteers who are appointed by judges serve as advocates for children who have been victims of abuse/neglect and who are caught up in the court system. Each CASA volunteer will usually have only one case and the goal is to help the court decide what is in the best interest of the child.

In addition to these programs, funding for prevention of child abuse and/or neglect is now being made available through the Children's Trust Fund. This fund was established by the Sixty-ninth Legislature and financed by an increase in the marriage license fee. Grants will be made available to community-based groups and individuals for prevention programs.

We must remind ourselves that most of these prevention programs will assist children and families in cases already largely removed from the caseloads of state protective services workers. While these preventative programs may help caseworkers by preventing Priority I and II cases from occurring, there is a limit to how much further they can ease caseloads. As we said earlier we must be concerned that the current caseloads, though smaller than six years ago, contain a higher percentage of difficult cases and it is unlikely that the problems of overwork, stress, and burnout have been proprotionately reduced with the caseloads.

We must also acknowledge that the caseloads are still above recognized standards. Unless we are prepared to revise our statutory responsibility in cases where child abuse and neglect has definitely occurred it is probable that we will need to increase staff in order to deal effectively with our current responsibility. The workload standards developed by DHS for protective services which have helped control caseloads also indicate the need for more workers. The legislative appropriations request of DHS for Protective Services is based in part on those standards and must be seriously considered even in difficult budgetary times. At the same time we must match our budgetary policy with a statutory policy as we review the role of the state in child abuse/neglect cases, devise coherent and workable definitions, and pursue overall a realistic and appropriately funded state policy. As we do so we must remember that one of the most essential elements for success will be caseloads that will be manageable and will enable child protective service workers to do the job they are trained to do and are eager to accomplish.

INTERIM CHARGE: To study the implementation of criminal background check legislation for child-care workers including the use of federal funds for caregiver training.

Background

In 1985, during the last legislative session, a bill was passed into law requiring the Texas Department of Human Services to conduct criminal background checks on certain individuals who work with children. Included in this law are employees of the Department who provide direct delivery of protective services for children, child-care facilities owners and their employees and adults living in homes used for child care, persons providing foster care for children, and volunteers with Big Brothers/Big Sisters of Texas. The intent of this legislation was to reduce the risk of physical and/or sexual abuse of children who are entrusted to the care of adults other than their parents. It was also the intent of this legislation to comply with federal guidelines that would provide funding for improving the quality of child care through training and public information.

The purpose of this study is to review how this legislation has been implemented with regard to child-care workers and how the federal funds that have been made available as a result of the passage of this legislation have been used.

Implementation of Background Checks on Child-care Workers

Under the provisions of the new law information regarding certain criminal offenses can be made available to employers or prospective employers of child-care workers. The criminal history that may be made available is limited to the following:

(1) a felony or misdemeanor classified as an offense against the family;
(2) a felony or misdemeanor classified as public indecency; or
(3) a felony violation of any statute intended to control the possession or distribution of a substance included in the Texas Controlled Substance Act.

The licensing branch of the Department of Human Services has been responsible for instituting procedures for conducting the criminal background checks of current or prospective child-care employees. Names submitted to licensing are checked with the Department of Public Safety for a possible match. If there is a match, licensing is notified and a representative of licensing then visits the facility and notifies the director. The director has the option of requiring the person to submit to thumbprinting, removing the person from the facility, or submitting a waiver/varience request to establish that that person has been rehabilitated.

For individuals that have not been recent or continuous residents of Texas, the licensing branch may also submit information, including fingerprints, to the F.B.I. for a possible match.

Since the law first took effect on September 1, 1985, up to June 25, 1986, a total of 62,704 names have been submitted to the Department of Public Safety for criminal background checks. Of these, the total number of relevant matches during that time has been 281. In addition, the total number of fingerprint cards sent to the F.B.I. is 2,185 with 3 relevant matches.

The breakdown on these matches is as follows:

Offenses Against the Person	Offenses Against the Family	Public Indecency	Drug Abuse
109	10	106	56

The disposition of the cases involve in these matches is as follows:

Convictions	Bond	Released	None
70	29	54	128

These statistics indicate that the use of criminal background checks is proving useful in identifying individuals whose employment or application for employment in child care situations should be carefully reviewed, and, depending on the exact circumstances and nature of the crimianl history, should not be entrusted with the care of children. What is not indicated in these statistics is the number pf potential applicants who have been or would be a clear threat to children but who will not be seeking employment in the child care field because of the existence of the criminal background checks. This deterence factor cannot be measured but it can be assumed to have at least some effect on weeding out individuals who should not be working with children.

Use of Federal Funds for Training

The federal program to provide funds for child care training and public information earmarked up to $25 million nationwide as a one-time allocation for this effort. Each state's share was based on its Title XX allocation percentage. Under the federal rules a state would receive only half their alloted amount if it did not pass a criminal background check law. With the passage of such a law in this state, Texas became eligible for its full share of these funds, a total of $1.6 million.

According to the federal guidelines for this program this money is to be used for training care givers, for public awareness about child care, and for training regulators of child care. The Department of Human Services requested proposals from groups and individuals interested in contracting for specific programs that relate to these areas.

In the request for proposals and in the eventual awarding of the contracts two factors were considered by the licensing branch of DHS: (1) That these funds were not likely to be again made available and were a one-time opportunity, and (2) that awards should be targeted to each of the three main areas of child care that the licensing branch regulates, child care centers, family home care, and 24-hour care facilities. In addition, the licensing

branch took into consideration the need to grant contracts that would assure geographic coverage of the state.

In order to increase the value of grant awards beyond the time the funds were available, licensing personnel considered proposals with components that could be used in the future. These include programs that developed training manuals or video tape instructional materials. Once developed such items could be duplicated at relatively low cost and be continuously available for training courses and workshops.

For example, a correspondence course is being developed aimed at family home providers as well as a video-tape self-instruction course that will provide training in child development and guidance, health and safety, nutrition and business management for home providers. A similar video-tape instruction program is targeted toward child care centers and includes management instruction for administors of licensed child care. Other contracts are designed for administrators and workers in 24-hour, institutional type care settings.

In order to assure wide geographic coverage it was necessary for the licensing branch to negotiate with some providers to offer programs in other areas of the state.

Eventually over thirty contracts were approved and in reviewing these it appears that the overall goal of providing training and public awareness to improve the quality of child care will be met. The Department will meet the general federal guidelines as well as its own guidelines for assuring that child care personnel are reached throughout the state in all types of child care that the Department regulates with the emphasis on materials that can be of continuing value.

CONTINUING CARE COMMUNITIES

INTERIM CHARGE: To study continuing care communities and other options for the well-elderly.

One of the most critical problems facing states today is the escalating costs of long-term care for their elderly citizens. In 1982, state and local governments paid $7.1 billion in total nursing home expenditures. (1) With the aging population growing at a rate three times faster than that of the general population, the cost of caring for the elderly will continue to rise rapidly in the years ahead. A recent government report estimated that almost 14% of the nation's population will be older than 65 by the year 2010. In an effort to slow this steady increase in costs, many states are looking at new ways to finance long-term care for the elderly. Cost, however, is not the only concern. State policymakers are recognizing that adequate long-term care means more than nursing home care; it involves a coordinated system of health care, social services and housing. To meet this need, a number of states are considering innovative models for long-term care that provide a total package of services to the elderly. (2)

At retirement age today, people are typically healthier, better-educated and more active than previous generations have been. Advances in medical care and in the general standard of living enable many to live vastly longer lives than their forebears. For persons born in 1984, average life expectancy is considered to be close to 75 years. It is not now uncommon for persons to live into their 80's and 90's. In a number of housing complexes for the elderly, the average age of the residents is between 80 and 83.

1. DEMOGRAPHIC TRENDS

Texas has the fifth largest "60 plus" population in the United States, exceeded only by California, New York, Pennsylvania and Florida. The numbers are growing rapidly. In 1984, there were more than 2.1 million Texans age 60 or older. By the year 2000, this number is projected to increase to more than 3 million--a 65% increase in a 20-year period. The most striking population increase is projected for the group age 75 and older. In the next 20 years, this group is projected to increase by more than 130%--from 524,000 in 1980 to over 619,000 in 1984 and then to more than 1.2 million in the year 2000. As of 1980, almost 24% (or 437,000) Texans age 60 and older lived alone and almost 33% (or 171,800) of those 75 and older lived alone. The general aging of this population as well as the increased participation of women in the work force (removed from traditional caretaker roles) are factors in this trend. It is not surprising that already the number of housing complexes designed for elderly persons has fallen well behind the demand and waiting lists for these units are long.

The physical, social and financial needs of elderly persons do not differ from those of other age groups altogether as a result of the aging process; there are powerful influences that can shape these needs. The most widespread and devastating effect of the retirement-age concept has been the

public attitude toward persons in this age group with the result being that of a lowered self-esteem and public regard. Retirement age has come to be accepted as a time of lowered expectations for acuity, achievement and the aging person's worth to the community. However, we have begun to realize that this "norm" expectancy does not truly apply to this population any more than to any other segment. The "young-old" (between the ages of 55-75) are relatively healthy,relatively affluent, relatively free from traditional responsibilities of family and work, increasingly well-educated and politically active. This young-old group, with relatively few limitations related to health, can live independently. The range of housing opportunities, therefore, should offer itself to enhancement and meaningful community participation. Some persons may need the options available for an aged "old-old" group (75 years and up) in contrast to the young-old. The old-old are the smallest, but fastest growing segment of the total population, having incomes averaging around or below poverty level. Many of these old-old need more supportive services and special services, features in their environment as health-related problems develop among them. Their options for full or partial employment are severely restricted as are their options for social contacts and other meaningful activities. Nevertheless, the majority of the elderly including those with serious medical conditions, are able to function with minimal support services within the community.

The idea of developing special housing for elderly persons in the United States originated in the 19th Century with religious congregations. Increased funding from religious groups and, eventually, governmental support, made it possible to create special housing for the elderly, but research has confirmed that the majority of retirement age persons prefer to remain where they are rather than to relocate to a retirement community or housing complex as long as they can function independent. Approximately 75% of retirement age persons own their own homes, but for owners and renters alike, the cost of remaining in their homes increases with years.

2. THE FUTURE OF HOUSING FOR THE ELDERLY

The critical and contributory factors affecting a person's ability to live independently are weighed to determine which of the three basic categories is most appropriate: (1) independent living; (2) semi-independent living; or (3) supported living. Even if an evaluation over a period of time indicates that the resident is moving toward another category, it does not necessarily mean the resident needs to live in a highly-structured setting, staffed by health care professionals--but it does mean that the living environment should lend a source of supportive services needed by the resident.(3)

It is anticipated that future residents will enter their retirement years healthier and more physically active than preceding generations were at that point in their lives. In addition to providing sufficient social space for gatherings and meetings, it may well be important to provide protected outdoor areas for sports activities and rest and relaxation. The National Center for Housing Management suggests making health care conveniently accessible by providing space for a community health service agency on the premises either rent-free or at a nominal charge. The same arrangement could be made with a private clinic or group of doctors. Readily available health maintenance services, outpatient and emergency services could play an important role which would afford the resident the greatest possible

3. HOUSING ALTERNATIVES FOR THE ELDERLY

a. Aging in Place

The majority of retirement-age persons own their homes and prefer to remain in their own homes as long as they can do so and function relatively independently. Shelter costs for owners and renters alike currently run 30-35% of their average income (in taxes and maintenance costs for owners; in rental rate increases and maintenance costs for renters). As they and their dwelling places age, more assistance is needed from community and government sources in order to maintain the property. Many decide, as they arrive at the "old-old" level, that health and safety considerations dictate a move to housing that better serves those needs.

b. Home Sharing

Some elderly persons are able to remain in their homes longer because they choose to share them with others. Two or three widows, for example, might share a house or an apartment rather than bear the expense and labor of maintaining separate dwellings. This might be an alternative particularly suited for small towns or rural settings. Another type of home sharing is exemplified by the experience of a religious congregation that acquired a ten-room apartment in an older building and renovated it to provide separate bedrooms for several elderly parishioners who shared the kitchen facilities, living and dining areas as well as the chores.

c. Extended Household/Echo Housing/Granny Flats

Members of several generations of some families arrange to occupy separate portions of the same dwelling place; for instance, a duplex, triplex or separate houses on the same tract of land. In Australia, the government erects a pre-fabricated dwelling called a "granny-flat," in a family-owned area such as the back yard; rents it out to a family member as long as the need exists and then removes it. This concept has been brought to the United States in the form of private enterprise, renamed "echo housing" to remove the stigma associated with the word "granny," but as a form of more or less temporary housing, it has come into conflict with zoning laws in some areas.

d. Mobile Homes/Modular Homes

Some persons of retirement age who seek to simplify their lifestyle and reduce the cost of living, sell their homes or terminate their leases and move into smaller quarters such as modular homes or mobile homes. In many cases, this decision coincides with relocation to a climate offering milder weather or an area that has vacation spot amenities. Particularly in trailer parks, but also in areas where modular housing is permitted, zoning difficulties and limited accessibility of shopping and service facilities are drawbacks. If, as the years advance, health problems arise, the difficulties can become insurmountable.

degree of independence as long as practical:

The following changes are predicted for the future:

a. The "virtually unlimited" health care benefits now provided for residents are an "unaffordable burden to the facilities." Newer facilities of this type will place limits on the amount of health care provided; residents will seek some form of health insurance to provide the rest.

b. Nursing home benefits and needs not covered by Medicare or existing insurance contracts will be addressed by major insurance companies through new forms of coverage.

c. Regulations to "monitor the development and operations of lifecare/continuing care communities" have been enacted in several states and will be in others to "provide useful protections for residents without strangling development of future communities."

d. Sources of funds for Medicaid, welfare, foodstamps, and similar programs might be used to fund lifecare communities at "little or no increase in overall cost to taxpayers." Funding for proprietary lifecare communities might come from investors using the property as a source of potential capital gains through resale of property.

e. A refundable entry fee for residents would provide the capital to develop a lifecare facility and the resulting lower interest and debt service charges would lower the operating costs. (Laventhol & Horwath, 1983 Survey) (4)

Loneliness and security is of deep concern for elderly persons. Many who are otherwise able to remain in their homes and live independently choose to enter housing for the elderly in order to free themselves from the threat of crime or harrassment that they fear has made their neighborhoods unsafe or themselves vulnerable. Such persons are usually among the first applicants for elderly housing they see being constructed in their own neighborhoods. They look for tangible means of protection, yet do not truly want to leave the neighborhoods which have become familiar to them through the years. They simply want to live in a building that offers an extra measure of protection against crime. Also, they tend to look for freedom from some of the barriers and other features of their homes which have become problems to them as a consequence of sensory or motor impairment. The opportunity to obtain the needed architectural features and some housekeeping assistance and other services in a housing complex enables them to function with relative independence rather than to be confined to their living quarters and have to hire someone to help them, or perhaps, to enter a nursing home for full-time care when only part-time assistance is needed.

e. Retirement Residences

Apartment houses and apartment hotels in many areas have been converted into residences for persons of retirement age and "pre-retirement age" (starting at 50 or 55) who can live independently but appreciate the security and convenience of a retiree-oriented building and the opportunity for companionship with peers. The typical retirement residence is a single high-rise building with efficiency or studio apartments and one-bedroom apartments; many of these have some apartments equipped with special features for disabled or handicapped tenants. The total number of units is typically fewer than 500. The building has at least one small and one large communal room where meetings, social events and adult educational classes may be held. In resort areas and vacation spots, retirement residences come equipped with swimming pools, tennis courts and other sorts of amenities. Units typical of these areas have balconies or small private patios.

f. Retirement Communities

Towns, villages and subdivisions have been created for the retirement age population and for those in the pre-retirement category. In the towns and to a lesser extent, in the villages, housing, in a middle-to-upper price bracket, is available in many forms: apartments, low-rise buildings, duplexes, triplexes and quadriplexes. The towns are self-contained entities with medical, financial and recreational and shopping facilities close to residential areas. Most retirement villages are situated next to existing urban or suburban centers of activies. A subdivision is a planned residential area within a pre-existing community affording the needed amenities. It provides a dwelling place--a single family house or space to park a mobile home--and in addition, usually a community building that functions as a meeting place and recreation center.

g. Group Homes

A group home is a part of a system of community-based residential dwellings with the resources to help elderly handicapped or disabled persons develop their potential to live independently. These resources include special architectural features and built-in furnishings which afford elderly persons some special accomodations.

h. Nursing Homes

Persons whose needs for health care are continuous but not acute, may be accomodated in nursing homes, which provide two levels of care. These levels are classified as "intermediate"--help with the routines of living such as getting up, walking, taking medication and personal grooming--as well as "skilled"--around-the-clock-nursing care. Fewer than 5% of the elderly live in nursing homes at any one time, but about 20% eventually enter one, at age 84 (on the average). Upon dismissal from a hospital when the acute stage of a serious illness has passed, an elderly person may be cared for

at home by family members, who may be assisted by a local hospice organization. The alternative often selected is a nursing home. According to a U.S. Senate report, studies of the characteristics and needs of the nursing home population in the United States, indicate that 15-20% of the persons in nursing homes are misplaced, having been forced into these institutions "simply because public programs could not give attention to alternative ways of meeting their needs outside of an institution." Of the 20,000 nursing homes in the United States, 6% are owned and operated by the federal government, mainly through the Veterans Administration. Community agencies and religious and fraternal groups operate 20% of these homes on a non-profit basis. The remaining 74%, private-owned, must make a profit in order to remain in operation. Although there are many fine examples of compassionately-managed and well-equipped nursing homes in the private sector as well as in the non-profit category, the Subcommittee on Long-Term Care of the Special Committee on Aging of the U.S. Senate, has reported that the majority fail to meet standards of acceptability.

i. Congregate Housing

Congregate housing offers private living quarter with access to services needed by persons not totally independent, yet not in need of nursing care. Each apartment has a kitchen or kitchenette, but there is also a central kitchen and dining room serving those who do not wish to cook any or all of their meals. Social and other supportive services are provided within the complex or made accessible. Activities are organized; some residents run small businesses, such as craft and gift shops or cleaning services on the premises. A variety of levels of needs for service can be accomodated, with the flexibility to provide for service changes when needs increase, or as sometimes happens, diminish. The latter has been observed in cases where depression resulting from an individual's difficulty in coping with an environment that has become uncomfortable has rendered the person relatively inactive. Moving from that environment into congregate housing which answers that individual's needs can eventually result in increasing the individual's feelings of capability and usefulness, and help relieve or eliminate the feelings of depression. This, in turn, can spur the person to make new efforts toward independence. Congregate housing thus varies in the constellation of services offered and utilized by residents. The ability to foresee and provide for future needs of tenants is especially important to sponsors and planners of congregate housing and lifecare, or "continuing care" communities. (5)

CONTINUING CARE, OR LIFECARE COMMUNITIES

The concept of lifecare can be applied to a retirement community of any kind, but generally means a retirement village or high-rise building or buildings with a health care center. Some facilities charge a simple monthly rental.

Others require a lump-sum endowment plus a monthly rental. Still others require only the endowment. Some lifecare contracts place the person's assets in the care of the management. Other contracts provide for the facility to take over the assets, which then may become property of management. In return, the management provides the resident with a dwelling place--most often, an apartment or shared house for the rest of the resident's life as well as health care as needs arise. Many such facilities, especially those sponsored by religious groups, provide funderal services. Some provide legal services, including asset management and and administration of the will.Other services, such as the availability of hot meals and part-time homemaker, and resources such as transportation to shopping areas and recreational centers, are included in the contract. Lifecare typically assures the resident of lifelong shelter and care, regardless of the number of years involved and the state of the resident's financial resources. According to a 1983 study by Laventhol & Howath, a national public accounting and consulting company, 1000-5000 such communities will be established by 1990 to meet the growing needs of the elderly who are in middle and upper-middle income brackets.

The CONTINUING CARE RETIREMENT COMMUNITY (CCRC)--though sometimes used synonymously with "lifecare" has for the most part replaced the concept of "lifecare." This concept is thought to be more financially realistic--but for those communities which still refer to themselves as "lifecare," we will want to be sure they, too, come under the statutory guidelines for Texas. The rapid growth in this industry requires some examination as to what guidelines are currently in place or perhaps need to be in place to ensure the residents as well as the developers of their continued viability. Generally, the community requires a substantial entrance fee plus a monthly fee and perhaps, more realistically, additional services for additional fees. The individual is assured of housing, social services and nursing care in a comfortable environment where friends and cordial relations can be developed. While the costs associated with continuing care are prohibitive for some, an estimated 60% of persons retiring today could afford some type of continuing care facility. In the last few years, the industry had grown to a figure of 100,000 persons by the year 1983 with an annual revenue in excess of $1 billion. Those who support the industry are convinced that it is a concept whose time has come; that it can be a value to millions of Americans and that public policy should support the industry's growth. Early studies have shown that CCRC residents are hospitalized less frequently and enjoy better health than others in comparable circumstances--at least in part because of the advantages of on-site health maintenance services and supportive care.

Proponents of the concept see the communities as an attractive option for an even larger share of the growing elderly population. They offer certain advantages that other long-term care arrangements cannot provide. Continuing care represents an alternative to institutionalization for older people who cannot, or do not want to, maintain their own homes for both health and financial reasons but who also do not want or need the extensive care provided in a nursing home. Unlike nursing homes and other retirement communities, CCRCs give their aging residents the assurance they can live independently as long as possible and then they can receive nurturing care and support services as long as needed. Another benefit is that the quality of care may be better than in other types of long-term care facilities. Studies have shown that the residents of continuing care facilities live 20% longer than the elderly population at large. They also tend to use health-care resources less than that of comparable facilities. The major advantages of continuing care is

that it is affordable to most elderly Americans, contrary to the notion that only the wealthy can afford the fees.

1. AFFORDABILITY

CCRCs are intended for a special segment of the older population in terms of age and income status. Most admission policies require of residents: a minimum age, usually age 65; a physical examination before entering the community with some requirement of residents relating to "health," and a minimum level of assets and monthly income.

According to AAHA, the average age of persons entering continuing care communities is 75. Most persons move into independent living units and are physically able to live without any or only minimal support care.

In terms of net worth, continuing care residents have assets and income at least sufficient to pay the entrance fee and monthly fees. According to the Pension Research Council, entrance fees in 1981 averaged $35,000 for a single person to $39,000 for a couple, while monthly fees averaged $600 for a single person to $800 for a couple. Entrance fees typically range from $10,000 to over $100,000 depending on such factors as the type of services provided by the community and the type of living accomodation selected by the resident.

In Texas, as of early 1986, the entrance fee of the 32 such communities ranged from $9,500 to $196,000 with the monthly fee averaging between $300 and $900.

Census information indicates the number of older people with sufficient income to afford at least the 1981 average monthly fees cited above plus daily necessities as well as some luxuries: According to 1981 Census Data, 2.1 million or 22% of all families headed by persons age 65 and older had 1981 yearly incomes of $25,000 or more or an average of nearly $2,100 per month. Of the persons age 65 and older living alone or with non relatives in 1981, 484,000 individuals, or 6%, had incomes of $20,000 or over--or an average of $1,700 per month.

The Pension Research Council reported in its findings that continuing care communities appear to be within the financial reach of a number of persons over the age of 70. This conclusion, no doubt, is based on the number of persons with sizable home equity, other assets and income. With regard to home equity, many older people are considered financially well-off because of home ownership. The 1981 median value of homes owned by the elderly was $44,000; and about 84% of older homeowners owned their homes free and clear. (6)

Residents often pay the entrance fees from proceeds derived from the sale of a house, which many elderly own debt free or from savings and other assets. Many pay monthly fees from a continuing source of income such as social security and other retirement benefits. Since some retirement benefits such as social security are raised with inflation, residents find that their income is generally able to keep pace with increased monthly fees.

This alternative to the nursing home and other forms of long-term care is increasingly attractive to many elderly persons because it guarantees lifetime care as well as housing, access to shopping areas, social and recreational activities as well as other services among one's peers as well as

it is affordable to most elderly Americans, contrary to the notion that only the wealthy can afford the fees.

2. FINANCIAL RISKS INVOLVED

With the promise of continuing care, however, have come problems associated with the financial risks inherent in making lifetime commitments of care. These risks are so serious that individuals who wish to enter continuing care facilities and government officials charged with protecting the public interest, should exercise caution and close scrutiny in regard to them. The promise of continuing care has too often been thwarted by inept management, mismanagement and outright fraud. As a result, scores of continuing care facilities have been forced to declare bankruptcy. (7) Those who urge caution also point to other dangers and concerns: residents of CCRCs are given no equity interest in the facility; when bankruptcy occurs, the senior citizen residents have no standing and lose all of whatever they have paid into the home. Many CCRCs are financed as real estate ventures with endowment fees being used to cover initial construction costs. Reserves are either not established or they are set too low to cover future needs. Some CCRCs are not actuarially sound and projections of future revenues and costs are incorrect. Some facilities use a "cash" accounting system rather than an "accrual" system, thereby grossly inflating their cash position and misrepresenting their solvency. Some CCRCs represent themselves as being affiliated with a religious denomination or church, giving the impression that those entities would back the operation if any serious financial problem should develop. Quite often this claim has turned out to be false. Some contracts are written in such a way that if a person decides even within a reasonable period of time that he or she does not want to stay at the facility, the entire endowment is lost and not returned even on a prorated basis. Instances have occurred where residents have not been told that the operating company was paying inflated prices for goods and services it purchased from other related--non-arms length corporations. (8)

The potential for financial mismanagement problems exists because of the complicated financing required to develop, construct and operate a CCRC. Without careful planning and application of actuarial principles, a community may be doomed to failure. Crucial to a CCRCs financial solvency is its ability to calculate accurately the residents' fees which are used to cover current and future capital and operating costs. CCRC managers must project the costs of future health care services for the residents and then establish a pricing policy to fund that obligation. They must also anticipate the mistakes that are often made in projecting the resident population in the years ahead, estimating the number of deaths and transfers to a nursing facility. The vacated apartment becomes available to a new resident who will pay a new fee. When a resident dies, the community now has unlimited access to any remaining entrance fee. This reliance on turnover is a concern to some critics of this care concept who see it as a disincentive to care for residents. Turnover of residents is essential to financial success and is the basis of establishing fees. Failure to use morbidity tables that ajust for the healthier CCRC population can result in an overstimation of the turnover rate and the setting of consequently lower revenues than expected. Another common error is a reluctance to raise the monthly fees to make up for earlier miscalculations in the rate structure. Residents on fixed incomes may not be able to meet higher

fees. If the community cannot make ends meet based on inaccurate expectations, the result will be financial disaster.

The potential for fraud exists merely because of the community's receipt of large entrance fees--perhaps totaling millions of dollars in the early years of operations before the expenses mount up. During this time, a fraudulent operator could divert this money to his or her own use rather than setting it up to pay for the future use of the residents. When the time comes to provide specialized care, there may not be enough money in reserves to pay for that care.

Because of this potential of mismanagement, most observers believe some form of regulation is needed to ensure the financial viability of CCRCs and to protect the welfare of the residents as well as to protect the reputable concept of the industry to the general public.

Consumer protection questions may include whether continuing care standards covering health care and social services and financial management practices among other areas should be set and, if so, whether the Federal Government or States should set such standards. At the present time, services and benefits vary considerably among communities. Some communities, however, might have to charge higher fees to residents to provide the added service or benefits required by government standards. Moreover, enforcement of such standards would require federal and/or state responsibilities, depending on the law and enforcement mechanisms established.

The individual who has invested a lifetime of savings and accumulation of assets in a continuing care facility unit may find that he does not have a strong voice if he has a voice at all, in the management of what is now his retirement home. Many states have enacted statutes which are designed to regulate elderly housing facilities in order to assure that residents of those faciliites have certain rights. The applicability of these statutes to a facility which provide differing levels of care is not well-defined. Assuring particular rights to individuals in these combination care facilities is of rising concern as the number of communities increase.

Continuing care communities are in all but eight states. New York does not permit them. (Recent efforts have been made to repeal that prohibition because of the mass exodus of New York residents choosing other states for retirement community benefits.) In 1981, states with the largest number of continuing care communities that met the Pension Research Council's definition of lifecare (continuing care) were:California with 36; Ohio with 22; and Illinois with 16. According to the American Association of Homes for the Aging (AAHA), the number of continuing care communities doubled from 1973 to 1983 and is expected to more than double again in the current decade.

About 97% of all continuing care communities are non-profit, which means they have non-profit Federal Income Tax status. In non-profit communities, entrance and monthly fees generally are not considered taxable income.Also, non-profits are exempt from real estate taxes in some states. Many non-profit communities are affiliated with a religious organization. In most instances, the religious organization appoints a controlling share of the board of directors, but it is not necessarily legally responsible for the

community's management, continuing operations, quality of care and financial stability.

The for-profit sector is showing increased interest in operating CCRCs. In for-profit communities, entrance fees may be considered income for tax purposes in the year the fees are received. Profits, therefore, are reduced by the amount of tax owed on the entrance fee for those organizations without tax-exempt status.

3. FEDERAL CONCERNS

Congressional interest in continuing care communities grew in the 1970's when some communities faced financial problems. These problems threatened the financial security of residents, many of whom used a significant percentage of their assets to enter them. In response to the problems, the Federal Trade Commission (FTC) investigated the facilities in the late 70's and early 1980's and initiated the guidelines that will be noted later in this study. As of November, 1985, 13 states have laws governing CCRCs; and Congress had considered proposals which would provide federal oversight of such communities if all states don't adopt such statutes.

In 1978, the FTC began investigating the management and marketing practices of some groups in the lifecare industry because of complaints it had received. The complaints were about sales presentations and promotional materials that allegedly misrepresented the medical care and other services to be provided by some life care communities as well as the costs of such services. In its investigations, the FTC targeted for-profit management companies. While the FTC did not find anyone violating the Federal Trade Commission Act, it found that one particular company, which provided services to 50 life care communities operating in 17 states, was engaged in what the FTC considered "unfair and deceptive" practices. While the company's officers did not admit violating the Act, they agreed to enter into a consent agreement with the FTC to cease and desist from certain practices. Some of the requirements in the agreement are summarized below because the FTC has indicated that these requirements might be useful guidelines for operators of continuing care communities:

The FTC agreement states generally that the company will not:

a. Indicate that there is an affiliation with a church or religious group if this is not true; and misrepresent the religious group in legal or moral responsibility for debts and commitments;

b. Say there is little or no financial risk involved in entering into a continuing care contract;

c. Say that a lender who holds a mortgage on a continuing care facility ensures the economical survival of the facility unless this is a fact;

d. Say that monthly fees will never be increased or that monthly fee increases will never exceed corresponding increases in

social security benefits and that service fee increases will not be limited by any other objective criteria if these factors are not true; or,

e. Say that reserve funds are established to ensure the community's financial ability to perform obligations, unless this is true.

In addition, the agreement requires the company to furnish its prospective residents information specifying:

(1) The continuing care community's affiliation with any religious denomination, organization or group and the extent to which these entities are responsible for debts;

(2) The resident's subordinate position to any mortgage lender or other creditor, if such is the case;

(3) The service fee increases, if such is the case;

(4) The existing reserve funds or other security funds such as escrow accounts and trusts, and the purpose of such funds;

(5) The parties having a financial interest in the lifecare community;

(6) Financial information available such as audited financial statements and financial statements covering annual income.

(9)

There are many federal programs available to continuing care community residents and community operators, but there are none specifically for CCRCs and their residents. For example, most residents are covered by Medicare. CCRCs qualify for medicare reimbursement when they provide skilled nursing care and other covered services to medicare-eligible residents. Similarly, communities with intermediate care facility services qualify for reimbursement under the Medicaid Program in behalf of Medicaid-eligible patients. Other programs for which life CCRC residents qualify are social service programs authorized under the Older Americans Act. Few CCRC residents, however, probably benefit from these programs because the law requires that they are to be concentrated on those with the greatest social and economic need. Other federal programs which are probably used by CCRC residents include ACTION's Volunteer Program where older people serve in community activities, and the Small Business Administration Service Corps of Retired Executives (SCORE) where volunteers provide business-related assistance to small businesses.

CCRC residents and CCRC sponsors do not qualify for federal housing programs because these programs are intended for low and moderate income persons and for homeowners and renters. CCRCs qualify for mortgage insurance under Section 232 of the National Housing Act as amended, which is administered by the Department of Housing and Urban Development (HUD). Through this program, HUD insures mortgages for new or rehabilitated skilled nursing facilities and intermediate care facilities as well as equipment to be used in these facilities. Two tax laws which impact the CCRC industry are: The

interest-free loan provision enacted in 1984 which treats interest-free loans as interest-bearing loans for tax purposes and the medical care deductions as it pertains to entrance fees.

4. TEXAS LEGISLATIVE CONCERNS

The distinquishing feature of the continuing care community is the contract. Under terms of the contract, which lasts for more than one year or life, the community promises to provide housing, health care and various other services and the resident agrees to pay, in advance, certain fees to help cover the cost of these services. Although the fees cover the cost of housing, these payments do not give the resident any ownership rights. The earlier CCRCs, then more commonly called "life care communities," required residents to turn over all of their assets in return for lifetime care, shelter and services. Today, most communities require the entrance fee plus a monthly fee and perhaps additional fees for certain other services. CCRCs may vary their fees on the type of housing selected and the number of occupants in each unit. As with any type of insurance plan, the advanced funding to future services provides the financial foundation of CCRCs. The community pools the revenues it collects from residents including entrance and monthly-fees, Medicaid and private insurance companies. Although residents selecting similar units will pay similar fees, the cost of providing services to them will vary simply because some will live longer than others and some will require more nursing care. In principle, the excess costs ocurred by these residents will be covered by the reserved pool of funds received from those who need fewer services. CCRCs are generally selective in admitting elderly individuals. Residents usually have to be a certain minimal age and have a certain minimal level of assets.

Another reason for the experienced increase in the number of CCRCs is that the expanding elderly population with its financial assets offers new business opportunities for the proprietary institutions. Although most are owned and operated by non-profit groups, an increasing number are under the management of for-profit corporations. In addition, more and more proprietary firms are becoming interested in developing CCRCs because of the opportunities for profits and income tax savings. Because of the climate and other factors, Texas, California and Florida are considered "prime targets." Currently, in Texas, 32 facilities consider themselves "continuing care communities." The first was in 1963, with twelve coming into existence since 1980. Land sales, developers, large construction contracts, marketing fees and management contractors --can all produce profits and depreciation of real estate resulting in tax benefits. Among those found in the CCRC business opportunity are architects, construction firms, real estate developers, proprietary nursing homes and hospitals.

This study of the issues surrounding such facilities will focus on appropriate state statutory laws as well as the rights of the individuals who are residents of a CCRC. The ideal CCRC is set up in such a way that the older person can sustain individual involvement in community projects and activities, develop a network of friends and maintain independent living in the first phase of his or her retirement years. This method of providing care is not typically available through general home care services nor is the amount of freedom typ cally available in the traditional nursing home. A semi-independent individual may buy a CCRC package which includes housing, meals, recreational facilities and services, laundry and bookkeeping services as well as medical

services. Such a package is usually "purchased" in one of three ways:

(1) Payment of an entry fee plus a payment of a monthly charge

(2) Purchase of a living unit with payment of a monthly charge

(3) Transfer of all assets to the organization pursuant to a CCRC contract

The potential of this type of care concept are quite desirable; therefore the goal of any guidelines from this Committee is to allow the benefits of the concept to be developed while remedying and preventing those problems which might hinder and even preclude such options as a form of alternative housing for the elderly.

It appears that most continuing care communities are managed effectively and are financially solvent and provide the types of housing and services set forth in the contractual agreement between the resident of the owner and the CCRC. There are some communities, however which have arisen affecting the residents' well-being as noted in hearings by the Senate Special Committee on Aging and cited in newspapers and magazines.

Howard Winklevoss, one of the authors of the Pension's Research Council's study, found that a problem inherent in financial management of CCRCs relates to the nature of cash flow in the first 15 years of a community's existence. In the early years, CCRCs show profits because health care utilization is usually quite low. Frequently, there is a tendency for communities to operate in a way that cash inflow equals cash outflow. At a future time, when health care utilization is needed by residents, the community discovers it has inadequate funds to cover its health care liability.

Another problem described by Winklevoss relates to using accounting methods generally applied to most industries, but that can prove inadequate for meeting actuarially-determined long-term care obligations. Winklevoss also found that problems have stemmed from board members who express concern when their non-profit communities show profits on behalf of the residents or to underprice their community rather than to consider that the health care guarantee inherent in CCRCs is a deferred obligation.

Particular attention should be given to the voice and bargaining positions accorded residents of CCRCs where such residents are required to sign agreements which are similar to a "lifecare" contract. The dangers in signing a lifecare contract may be great since the resident may suffer a loss of future bargaining power with respect to the quality of care and services rendered. The life savings of elderly persons have been lost under contracts which refused to return any of their entrance funds even upon discharge of the residents. Moreover, the possibility of the CCRC sponsors' bankruptcy is an ever-present risk. Despite these inequitable prospects,only 14 states regulate lifecare or continuing care community contracts to any degree at all. Though Texas has a Disclosure Law, it has no actual means of protecting the consumer's investment. This statute does not define a "life contract" per se, but does define the terms "life interest" and "long term lease."

The elderly person deciding to enter a life care residence is actually making a final home decision. This selection appears even more final in the light

of the substantial admission fee which the CCRC facility charges the resident and the dim prospect of the resident recovering any substantial portion of that fee in the event the resident finds himself unhappy with the facility or its management. Thus, a resident may decide to remain a resident of the facility because of the potentially devastating economic consequences of leaving in spite of dissatisfaction with certain aspects of facility operations.

Residents have a number of commonly expressed complaints:

a. Dissatisfaction with monthly fee increases which occur without explanation

b. Inability to provide input into the facility

c. Procedures and policies of the facility

d. Decisions made regarding the appropriateness of increasing the care provided

e. Poor security or poor maintenance of the facilities

f. The possibility of discharge or transfer without cause

To the extent residents of such facilities are protected at all, their rights are governed by one of two types of legislation--"lifecare" or "resident's rights" statutes. Fourteen states have lifecare regulations while 28 states have resident's rights statutes. Any such legislation is unlikely to provide sufficient protection to residents of lifecare or CCRC facilities for the reasons outlined in the following paragraphs:

> Most lifecare regulation is concerned with the licensing and the certification of the lifecare facility and certain disclosure with respect to the lifecare contract. The lifecare legislation appears to assure the lifecare residents few, if any, specific rights with respect to the operation and management of the facility and the personal liberty of the residents. Current legislation does not appear to be comprehensive enough.
>
> States with both lifecare and resident's rights statutes could remedy this situation by requiring that the residents' rights provisions be incorporated into the lifecare or continuing care contract, with the contract setting forth how much voice the residents will have in the management and financial decisions affecting the facility.

In contrast, most resident's rights legislation, though sufficiently comprehensive in scope, appears to protect only residents or patients of a skilled nursing facility or an intermediate care facility. An older person residing in a lifecare community is often only steps away from a skilled nursing or intermediate care facility. If the resident's facility does not meet the definition of a skilled nursing care or an intermediate care facility, the resident will not be protected by the resident's rights statutes. Such

residents are, at best protected only to the extent of the rights guaranteed under their particular contract with their particular provider.

CCRC statutes may mandate disclosure of certain information not required to be disclosed to residents under resident's rights statutes. The disclosure most commonly required by CCRC statutes is the financial statement of the institute providing care. Most such statutes require that the financial statement of the contract be attached to the contract or made available to the resident prior to contract acceptance. Other commonly-mandated disclosure requirements under CCRC laws include the terms and conditions of cancellation of the contract and refund policy; circumstances in which the resident is permitted to remain in the facility in the event of possible financial difficulties; conditions under which a 'living unit' occupied by a resident marries while at the facility and a statement of whether the provider of care and services is affiliated with a religious non-profit or proprietary organization or entity. These disclosure requirements are important to the individual residents and their families.

(1) Residents' Rights Statutes

Many of the enumerated rights in residents' rights statutes seem so constitutionally basic, it almost appears unnecessary to have them put into statute. They are necessarily important however, and this Committee wants to assure those rights by at the very least some reference to those rights. These residents' rights are especially critical to define where an individual is institutionalized in a setting removed from the rest of the community. The majority of resident rights statutes contain provisions concerning the quality of care received; the amount of management input; protection from harrassment due to the filing of grievances and complaints; adequate security and maintenance of the facilities and protection from transfer or discharge without just cause. In addition to providing for adequate and appropriate medical treatment, several states' resident rights statutes require courteous and respectful care. Most states also refer to the resident's conduct. Such statutes seek to protect a patient or a resident's exercise of individual liberties and to uphold his or her personal integrity and respect by seeting forth in explicit statutory language the following rights:

(a) The right to maintain control over his/her personal affairs.

(b) The right to associate with persons of his/her choice either by mail, telephone or private visits.

(c) The right to exercise civil rights and the right to vote.

(d) The right to enjoy religious obligations and activities.

(e) The right to an individual and cultural identity.

(f) The right to participate in social and group activities. (10)

Most also encourage residents to voice grievances with a freedom from fear, restraint, reprisal or interference. The residents' rights

statutes further protect and assure the resident of his or her rights through several different and explicit provisions which pertain to privacy in a resident's communications, personal and medical records and bodily, personal and medical programs as a whole.A few states also assure the resident of additional privacy rights through a provision which requires any facility staff member to make his or her presence known before entering a resident's living unit or occupancy room. Provisions found in a few of the statutes may be even more important in addressing the concerns of older Americans in a CCRC who have entered into a contract with the expectations that they will continue to exercise the same liberties enjoyed before entering the facility. Such liberties are those relating to individual freedom, dignity and respect. These liberties include the right to consume alcoholic beverages; to use tobacco products and to rise and retire when desired and to enter and leave the facility unless medically-contraindicated and additional provisions commonly found in the resident's rights regulations reserves the choice of physicians and pharmacies to the resident if so desired. Certainly, these amenities, etc., may vary according to communities, but should be clearly outlined in any agreement between residents and contractual agreements.

2. Provisions Not Found in Most Resident Rights' Statutes

An important concern of the older American is the quality of care provided by the facility. Unless the CCRC facility guarantees a certain quality of care in its agreements or the facility is in a state with a lifecare statute which does so, the CCRC facility residents are at a disadvantage in asserting their right to adequate and appropriate care, services and medical treatment. Another threat to many individual patients of skilled nursing or intermediate care facility is the threat of transfer out of the facility. This is a potentially equal threat to residents of CCRCs who have been promised skilled or intermediate nursing care when needed under the terms of their contract with the CCRC provided. One of the greatest transfer problems arises from the shock and ajdustment an elderly individual is forced to endure when he or she leaves behind friends acquired in the former location --friends who may not be able to give support or friendship to the transferred resident in his or her new location. The effect of this transfer may be to reduce the transferred resident's responsiveness to treatment. (11)

The threat of transfer is a greater concern for those residents of facilities where multi-level care is not offered on the same premises and increased care can only be obtained off the premises as well as where the facility and its staff can make the decision as to when and whether or not to effect a transfer.

Many CCRC facilities,however, avoid the major concerns of transfer by offering a multi-level concept of care on the premises which permits the resident who may initially enter the facility to live in an independent living unit or apartment to remain in the facility even though his or her health needs change. This appears to be one of the best alternatives to the traditional lifecare retirement home or "rest home" in which residents live in rooms and receive personal care but may

eventually be transferred to an entirely new location when the need for a level of care greater than that of personal care arises.

Although most statutes would not apply to the CCRC facility, there should be some potential statutes to the skilled nursing and intermediate care portions of the facility as well as the living unit portions. In reality, these lifecare retirement communities are a combination of living units and specialized care facilities which may or may not be located on the same premises as the living units or on a different premises. Nevertheless, the concept of providing total care to a CCRC facility is the same as for other types of care facilities. A resident can move from one level of care to another as his/her condition deteriorates with age. The CCRC facility should therefore be assured of the same rights regardless of the level of care required. Under the 'total care' concept system, the living units of the CCRC should be considered part of the total system.

Ohio's Residents' Rights Statutes serve as an example. The statutory provisions are applicable to a home--and a home is defined as a residential facility or institution accommodating three or more individuals who are dependent upon the services of others. A home here would not appear to include a CCRC facility which principally requires that its applicants be self-sufficient individuals not dependent upon the services of others.

The Wisconsin Statute pertains to a nursing home or a community-based residential facility which is defined to be a place in which at least three adults require care, treatment or services above the level of room and board but not a level for adults who are ambulatory and self-sufficient in addition to personal care or intermediate care.

In Maine, a long-term care facility, including by definition, a boarding care facility, is required to inform residents of their right to form a council. The establishment of such a resident's council is not a statutory mandate but is optional, i.e., dependent upon the majority vote of the residents. If a council is established, it must draw up by-laws and meet at least quarterly. The statute also provides that membership is to be off-limits to facility employees or representatives; family members may sit in on the council meetings but may not be members. The Residents' Council in Maine is essentially responsible for disseminating information regarding residents' rights and reviewing the facility's policies and procedures relating to residents' rights.(12) Each elderly person facing the possibility of institutionalization and retirement housing should be protected by a constitutionally-applied residents' rights statute. State legislators and other interested constituents should act to ensure the right of residents for all kinds of facilities for the elderly. This need for action is particularly acute as elderly housing facilities and alternatives increase with the aging of the population. (13)

Several areas of legislative options have to be considered as we prepare guidelines for Texas. Legislation at the state level seems more appropriate for most states. Generally, because the detail required

and the nature of the subject matter, the type of regulation envisioned appears more suited to state administration than to federal supervision, Secondly, CCRCs are still relatively new, and at least at present, it would be advantageous to encourage the variety of legislative programs that would develop at the de-centralized state level. Thirdly, a jurisdictional problem exists whenever the federal government attempts to regulate essentially-local institutions.

Based on the first comprehensive study of continuing care retirement communities, it is known that the institutions variously referred to as life care, continuing care, perpetual care, residence care and life lease are anything but homogenous. (14) Communities differ significantly in substance depending upon the resident's termination rights for the community and the resident; the amount of services and medical care covered under the contract at no or perhaps a nominal extra charge; the length of the contract and the financing arrangements between the resident and the community--all are factors to be considered in the many differing types of available packages. Given these diverse characteristics of CCRCs, it is absolutely essential to draft a definition to ensure that all types of CCRCs will be brought within the scope of the statute. Given the conclusion that legislation will be appropriate in many states, it should not be surprising that to consider the definitions section of the CCRC statute to be an absolute necessity. The definitional element of regulation clearly should fall with the first category described in the introduction of a governing statute of the resident (including mutually terminal continuing care contracts which provide either on-site or contractual shelter and various care services; that provide for either a payment of an entrance fee or periodic payments or a combination of the two; and that are not completely based on a fee-for-service theory of payment if there is any pre-payment). The theory behind certification requirements is that some sort of comprehensive application process complete with required submissions, will enable the regulatory agency to determine the financial stability, capacity, sincerity and integrity of prospective and existing continuing care operators. Such prospective certification, coupled with annual monitoring and various enforcement provisions, is the major mechanism used to supervise the financial stability of the continuing care industry by the states which have adopted comprehensive statutes and legislation. Provisions on certification should contain two independent types of legislation. First, they should include provisions for certification procedures to be applied only to new prospective operators who have not yet acquired the necessary facilities or land or who have not yet begun construction of a CCRC. Such operators should be required to submit advertising, organizational information, a statement of proposed location and future viability of the facility. After review of these submissions, the responsible agency should have the authority to issue a provisional certificate that entitles the applicant to collect deposits from prospective residents; to pursue contractual commitments with contractors and to start out on the path toward permanent certification. An exemption that has some merit for consideration would be an approved self-accreditation program.

Second, all CCRCs presently operating and all new communities following

the provisional certification procedure should be required to apply for and receive permanent certification in order to sell or offer to sell continuing care contracts. Applications for certification should be developed by the responsible administering agency. A number of attachments to the application should be required. To apply for and to receive permanent certification in order to sell or offer to sell continuing care contracts, applications for certification should be developed by the responsible administering agency.

Ownership and financial responsible disclosure statements, a copy of the disclosure statements required for distribution to residents elsewhere in the statute and a series of actual projected financial statements should be included. Once a certificate of authority to operate is issued by the administering agency, it should remain perpetually valid, subject to the revocation procedures provided for elsewhere in the statute. Notwithstanding this conclusion, there should be a requirement of filing annual reports, consisting of current financial statements as well as notification of any changes from information on file with the administering agency. In this way, all of the benefits of certification could be achieved while minimizing the administrative burdens of the oversight agency. Finally, members of approved self-accreditation should be required to file the annual reports with the responsible administering agency. This requirement is included to ensure that there is one central repository for all relevant information on each CCRC operating in the state.

3. Escrow

The basic view underlying escrow provisions is that some extra protection is needed for the resident's investment beyond disclosure, certification and enforcement of other regulatory provisions--at least in certain instances. The objection to mandated escrow provisions is that, by definition, they direct capital into relatively stagnant bank accounts or other relatively unproductive uses of money; thereby depriving residents of the full value of their money in that part of their investment is not working as efficiently as it might.

Two basic approaches to escrow requirements could be used. The first approach would be to require an entrance fee and deposit escrow until the resident moves into the community, or until some other point in time, at which point all funds are released to the operator. This second requirement is typically imposed by a bonding authority or bank holding a mortgage or lien on the property.

Existing state statutes approach in varying ways the issue of when funds should be released from the escrow account. For example, California's statute permits the entrance fee escrow to be released when the facility is 50% completed and 50% subscribed. The Arizona, Minnesota and AAHA Statutes, however, have more complicated formulae governing release of the escrow funds, depending upon whether the unit is new or old and, against this background, it seems to be helpful to isolate three different types of problems which entrance fee escrow could arguably ameliorate:

a. First, a totally unscrupulous operator could commit fraud by absconding with the residents' entrance fees. Of course, this type of fraud could theoretically occur at any point in the life of a CCRC. The likelihood of this type of fraud, however, is greatest before the resident occupies his/her unit. Additionally, special protections might be advisable in the case of an operator who has not yet constructed the facility, but is collecting entrance fees.

b. Second, in the case of a new CCRC, the use of an entrance fee escrow is one mechanism to ensure that the community is in a position to meet the expectations of the promoter. A primary assumption made by the developer of any community is that the operator of a new community can attract a certain number of residents at a certain price to "buy in" to that facility. By forcing a CCRC to hold all of its entrance fee in escrow until a certain percentage of its capacity is subscribed to, one can statutorily ensure the accuracy of this crucial assumption.

c. Third, an escrow requirement could be used to help ensure the financial stability of the CCRC. Thus, it could be argued that any community maintaining a certain level of cash would be financially stable and secure.

Balancing all of these considerations has led to the conclusion that two types of entrance fee escrows could be required by statute. All entrance fees, including refundable deposits in excess of 5% of the existing and operating communities for occupied units before the resident takes occupancy should be held in a cash escrow account. For the purpose of this section any escrow required by a bonding authority or a bank holding the mortgage on the community or its property, for either construction or permanent financing should be considered to count against the requirements of the statute. Thus, the statute's escrow requirement should be concurrent with any escrow requirements established as a result of a private contract for funds held in this second type of escrow account. The entrance fee should be released when all of the following conditions are met:

The CCRC becomes 50% subscribed through receipt of entrance fees from a sufficient number of residents to fill 50% of the community.

Commitments have been secured for both construction and long-term financing. Further, any conditions that must be met to activate those commitments before disbursement of funds thereunder, other than completion of the construction or closing of the purchase of the community must be satisfied.

Aggregate entrance fees received by or pledged to the provider plus anticipated proceeds from any long-term financing commitment plus funds from other sources in the actual possession of the provider must equal not less than 90% of the funds necessary to fund start-up losses of the community.

The most controversial aspect of this proposed statutory requirement --the release formula for the entrance fee escrow in a new community represents a delicate balance among the various options discussed above. On the one hand, the proposed approach would make these funds available to the operator as soon as is practical in a policy sense; on the other hand, in order to protect the residents from fraud and to ensure the integrity of the assumptions in the feasibility study, funds would not be released to the provider until it has received substantial commitments from potential residents and from sources of both short and long-term funds.

The apparent harshness of the third requirement should be lessened at least in part by the statutory provisions that the statute's escrow requirements be concurrent with, and not additional to, any escrow accounts entered into as a result of a private contract. Because of the private market protective mechanism that will come into play, no additional protection appears necessary to residents once the statutory requirements have been satisfied. Thus, the bank or bonding authority releasing funds to the provider under construction or permanent financing commitments should be policing the hopeful operator to protect against fraud. The interest of such entities to see that the community's construction is completed is as powerful as that of potential residents. Because these lenders,or financiers, are sufficiently sophisticated to protect the interest of the residents, admittedly for different reasons, no additional statutory protection seems necessary at this time.

The major argument in favor of reserves is to ensure that the CCRC can provide the services associated with the deferred liability for which it has contracted with its residents. Applications of sound principles of actuarial science to determine liability associated with CCRCs thereby resulting in the establishment of actuarially sound reserves, could be the most significant contribution of this study to the continued viability of the CCRC industry. Thus, the maintenance of actuarially sound reserves by all CCRCs should serve as the best protection residents can expect, both in terms of the sound financial planning that such a practice would bring to the continuing care industry and in terms of the inherent early warning signaling device that such a procedure would produce. Residents expect and are entitled to a basic guarantee that their community will retain the essential financial wherewithal over the years to provide the services to which it has committed itself contractually--- without the need to have monthly fees increase faster than inflation. This would appear to be a desirable goal of a CCRC. Mandating actuarially sound reserves is the best long-term legislation solution. States are reluctant to make a definitive prescription as to actuarially sound reserves and liquid asset requirements at this stage of the research because of the risks that such a standard would be either too harsh or too weak, given the limited scope of studies done so far. (15)

4. Bonding

Bonding refers to a fidelity bond which is obtained by the CCRC in order to cover losses owing to the dishonesty or negligence of employees

handling residents' money--or a Surety Bond, which is obtained by the community as a substitute for, or in addition to, the reserve requirements just discussed.

Current practice is relatively consistent and easy to discern. Although only the California statute requires a fidelity bond for agents and employees who handle substantial sums of money, bonds covering the fidelity of employees are common in all industries in which the money of third parties is routinely handled by employees, including the CCRC industry. Ironically, though several state statutes require or authorize the administering agency to require the filing of surety bonds under certain circumstances, no instances are known of at this time where a CCRC has obtained a surety bond to ensure its financial stability.With respect to fidelity bonds, it does appear necessary to include a statutory provision mandating CCRC operators to obtain fidelity bonds for their employees. Even if obtainable, surety bonds would probably be prohibitively expensive. Also, the surety bond might have a poor incentive effect on a community's management. In short, it is better to run a community well than to rely on a surety bond. Additionally, there are difficult administrative problems involved in determining the size of a surety bond for individual communities. Finally, the entire theory of reserves is that communities maintaining an actuarially sound reserve will have no need for further intrusive regulation of economic and financial status. Imposing a bonding requirement in addition to the reserve equipment would be superflous. (16)

5. Fee Regulation

The ultimate in intrusive regulation perceived is a direct setting of fees by the state or supervision of a fee-setting by the state. Such fee regulation might be modeled after the extensive regulation of rates commonplace in the insurance industry. It is the Committee's shared conclusion that no such fee regulation provision is appropriate in any state legislation scheme. Not surprisingly, all current existing and proposed pieces of legislation concur in this judgment and do not contain entrance fee regulation provisions.

The appropriate entrance fee setting by CCRC operators is complicated yet essential to the welfare of the residents. It is recognized that operators might set fees too high, thereby gouging the residents--or that they might set fees too low, thereby attracting residents away from more financially stable communities and ensuring the collapse of their own communities. The frequent comparisons that have been made between the CCRC industry and the insurance industry are also noted, but the solution to this complex and critical problem is not fee regulation by the state. There is no evidence that the state is any better suited for the fee-setting decisions than a community involvement would be of such structure. The goal of improving the information on which CCRC operators base their decisions was, of course, a major consideration in the decision to go forward with specific guidelines.

Though there now exists a statute which relates to disclosure in Texas,

problems do exist when relying solely on even a comprehensive disclosure requirement to protect resident rights. Just providing information may not equalize bargaining power between resident and providers --the information must also be comprehensible. Because, by its nature, financial information is complex, disclosure of only raw financial data is probably not effective in its major goal of equalizing bargaining power. Additionally, if because of age or educational background, residents are inherently weaker bargaining partners than operators, disclosure will not necessarily equalize bargaining power. Thus, the efficacy of disclosure is linked to the validity of the assumption that lack of information is the sole or major cause of the disparity in bargaining power.

Finally, the assumption that operators will not allow their facilities to deteriorate for fear of not attracting new residents requires close examination. Even if this were the case in most communities, the size and unrecoverable nature of each resident's investment in a CCRC does not safeguard the continued viability of CCRCs. It would seem that disclosure of CCRCs with respect to the disclosure element of regulation suggests that comprehensive requirements of such will not impose additional expensive burdens on most CCRCs. The disclosure provisions that might be considered fall into three general types:

a. Those that allow general public inspection on requests of financial statements and annual reports filed with the administering agency. Such a right is available to prospective residents, current residents and the general public.

b. Those that require CCRC providers to furnish copies of specified disclosure material of varying content to all prospective residents or their advisors before execution of the contract.

c. Those that require CCRC providers to furnish annual disclosure statements to current residents.

In summation, if the surveys of existing CCRCs and existing statutes are any test at all, financial disclosure to residents is something that virtually every person associated with the CCRC industry can agree upon. The financial disclosure of the regulation appears to be essential to good legislation.

The forms and contents of disclosure are critical. States should require the use of a disclosure form that provides a complete summary of the CCRC current an long-range financial picture. The form should be completed and submitted to the administering agency annually. All prospective residents should be given a copy of a simplified disclosure form annually and upon request. Finally, residents and their advisors should be permitted access to the community's full financial and income statements as well as to reports of any feasibility studies conducted. This right of inspection should be stated clearly and conspicuously on the simplified disclosure form. (18)

A regulatory provision governing the contents of the continuing care agreement as well as a regulation mandating full disclosure attempt

to equalize the bargaining power between providers and prospective residents. By regulating the contents of disclosure statements, contracts (size and plain-English requirements), refunds and termination rights, the state can, in a relatively unintrusive manner, ensure that the agreement reached and signed between the CCRC and the resident contain some basic protection for the resident and approximates a contract that would be reached between the negotiators of equal bargaining strength. Further, regulation of certain substantive terms has the incidental benefit of reducing uncertainty, and therefore, simplifying much of the litigation surrounding continuing care.

Arguments that the form and contents of continuing care agreements should not be regulated in any way are rarely encountered. To circumvent the possibility that a CCRC would adhere to a limited requirement of state regulation, it would seem necessary that the guidelines set forth in statute should be particularly comprehensive; protective of the industry and the resident, yet allowing flexibility in whatever uniqueness any particular community might choose to offer. Most significantly, and with some justification, there has been an increasing resistance to state legislation which, in effect, provides a standard form contract that each CCRC is required to adopt.

State legislation should impose a plain-English requirement on all contracts for continuing care providers. Such provisions can be modeled after several provisions found in several pieces of consumer protection legislation enacted at both the state and federal levels over the past five-to-ten years.

The state legislation should require that the disclosure data provided to the responsible regulatory agancy should be sufficient as to address all areas identified in the statute and approval of the facility contingent upon strict compliance with the guidelines of the statute.The legislation should also require existing CCRCs to submit such disclosure to the responsible agency. Agency approval requirements, however, should apply only to future continuing care facilities; that is,existing agreements should, unless blatantly in conflict with general responsibilities be "grandfathered." The disclosure data as approved by the regulatory agency must be provided to the prospective resident before the contract is signed.

Any CCRC that attempts to limit the permissible increase in monthly fees should be prohibited. Although the state legislation should not generally impose a word-for-word provision for continuing care contracts, it should require certain statements dealing with the following issues:

a. The value of assets transferred to the CCRC; initial amount of monthly fees and the manner of changing monthly fees should be stated in the contract. Any health or financial condition of a resident should be set forth in detail. The particular living unit contracted for by the applying resident should be disclosed in the contract.

b. A provision governing dual occupancy of residency units should be included in all contracts. This provision should specify what

occurs when one of the two residents dies, withdraws, is dismissed or needs to be transferred to a health facility.

c. Provisions governing the reoccupancy of residential living units as a result of prolonged sicknesses should be included in the contract.

d. The contract should list all services to be provided and any surcharges that might be levied. The contract should specify that it creates no property interest of any kind, that it simply is a service agreement.

The refund provision should be clearly stated in the text of the contract, either in boldface type or in type larger than the rest of the body of the contract. Full refunds, less a nominal processing fee should be mandated in the case of death or withdrawal before the resident takes occupancy of the unit. The refund policies of the community on either withdrawal by the resident or dismissal by the CCRC should be explicitly stated. As a recommendation, but not a requirement, the state legislation might contain a section providing for a probationary refund. Finally, the contingency of death after occupancy should be addressed explicitly in each CCRC contract.

Each contract should provide a cooling-off period of at least seven days following an execution of the contract, during which the resident may elect to cancel the contract with a full refund to the resident of all fees paid to the CCRC, less reasonable costs. Similarly, the CCRC's rights of dismissal should be clearly stated in the contract. Any state statute should include a good-cause limitation on the dismissal power of the community. Residents should also be protected against eviction and retaliation for complaints against the community.

A provision explaining clearly what can happen to the resident who is unable to continue to afford the monthly payments should be in each continuing care contract.

In order to combat some of the potential harm of institutionalization, as well as the theoretical disincentive to care that may be present in some CCRCs, it has been argued that it is advisable to grant rights of self-organization to residents. By giving residents a voice and a role in a community's goverance, one is, in effect, charging them with partial responsibility for assuring that the community function smoothly and efficiently. Like disclosure, therefore, this element is designed to give residents the power and information to safeguard their own interests. Further, residents can often bring great insight and wisdom to the goverance of a CCRC. Whether this should be mandatory or left to each individual community rather than recommended by or prohibited by law allows for some further consideration.

A regulation provision on residents rights to organize should be appropriate in any state which provides statutory guidelines for CCRCs,

but such a provision should not require that any resident serve on the facility's board of directors.

6. Advertising

The primary public policy behind all types of advertising regulation is an attempt to reduce misinformation and minimize the significance of weak bargaining power on the part of the residents by ensuring that CCRC advertising and solicitation materials are accurate and not subject to misinterpretation. Advertising regulation is a basic anti-fraud protection common in many industries and deceptive practices addressed in Texas statutes. Some form of advertising regulation is an appropriate consideration for the CCRC industry. An unscrupulous advertisement suggesting a relationship between the community and some well-known entity either intentionally or negligently could mislead the prospective residents. Advertisement includes media, promotional and solicitation literature but excludes such items as community newsletters and routine correspondence to current and prospective residents. Misleading advertising, especially ads that imply the existence of financial connections between CCRCs and unrelated but well-known and respected organizations in the literature should be prohibited. Any mention of outside, but unaffiliated organizations in the literature should be noted by an explanation of the financial connection between those organizations and the community in the initial disclosure data provided to the responsible administering agency. Deceptive advertising practices and penalties, both civil and criminal, are defined in Texas statutes under Deceptive Advertising, Section 17.12 as well as under the Business and Commerce Code, Deceptive Trade Practices Act, Section 17.14 et seq., V.T.C.S.

7. Responsible Administering Agency

A responsible administering agency should have both the expertise and the interest necessary to administer whatever regulatory program the state develops. Once the decision has been made to enact the statute, it is essential that the statute include a provision vesting regulatory discretion in some administrative agency. Current practice allows such discretion in the department of insurance in four states; the department of social security in one state; the office of aging in one; the securities bureau in two states; and one state has created a board of examiners of lifecare.

Ideally, perhaps, what one would expect to be most appropriate would be some sort of form or blend of social service, health, actuarial and aging skills. Should an advisory board be created, it should be made up of attorneys, residents and administrators of CCRCs, actuaries and other appropriate members with a geographical representation also considered.

No matter what form a regulatory scheme takes, and regardless of whether it is administered by government or private sources, enforcement of its provisions is essential. Investigation and audit capabilities are cru-

cial to the enforcement power of the entity responsible. Full investigative authority should be invested in the administering agency. This authority should extend both to on-site inspections and to examinations and financial audits.

Second, strong civil and criminal penalties should be included to ensure the compliance of CCRC administrators with the statutory requirements. Third, full subpoena power should be given to the adminstering agency. Fourth, the basic remedial authority of the administering agency should require that agency to notify the noncomplying provider of its violation and the provider given an opportunity to correct the violation. The basic tools available to the administering agency should include the authority to impose a cease and desist order to seek injunctive relief in the courts and the appointment of examiners to seek injunctive relief in the courts and the appointment of examiners to supervise compliance with court or agency order. Such methods permit the operator to continue to run the facility, a feature of some importance because of his or her specialized knowledge of that particular community.

This type of comprehensive statute proposed coupled with the investigative and enforcement measures seem all that is necessary to ensure proper operation of CCRCs. Some states have determined that the proposed provisions have also included a provision permitting the administering agency and the court to appoint an outside person to assume operation of a financially-troubled CCRC. Some states may find such rehabilitative mechanisms advisable. The use of rehabilitation procedures that displace the operator from the community should be carefully limited to cases of actual fraud or gross mismanagement. The chances for successful rehabilitation in other such cases are greatly enhanced if the CCRC provider remains in possession while working with the administering agency to comply with needed corrections.

No provision is considered necessary which would prohibit proprietary operators from offering CCRC contracts. To the extent that the state is concerned about fraud, conflict of interest, and self-dealing abuses that have been argued are inherent in such arrangements, the appropriate vehicle with which to regulate such abuses is the state non-profit corporation law. (19)

8. Gaps in Existing Texas Statutes

The statutes which Texas now has which can possibly apply as consumer protection are in Chapter 102 of the Human Resources Code which relate solely to disclosure or financial data as well as the Deceptive Trade Practices-Consumer Protection Act (Section 17.41 et seq, Business and Commerce Code). The purpose of this law is to protect consumers from false, misleading, deceptive or unconscionable business practices. This is the statute that is used most often against "shady" business. Another statute that might apply relates to home solicitation transactions. Article 5069-12.01, et seq., Vernon's Texas Civil Statutes, applies when a person personally solicts a

consumer in the consumer's home and the contract for the sale of goods or services is signed in the consumer's home. This law permits the consumer to cancel the contract within three days of the date of the transaction.

At the inception of this Committee's study, Texas Association of Homes for the Aging (TAHA) conducted a survey of 29 facilities identifying themselves as continuing care communities. Of those surveyed, only 10 acknowledged any awareness of any statutes which applied specifically to their facilities. At the Human Services Committee Sub-committee Hearing on this subject held June 12, 1986, Dave Talbot of the Attorney General's Consumer Affairs Division presented testimony regarding the difficulties involved in the prosecution of unscrupulous developers and facilities that have already occurred in Texas.

The concensus of concerned leaders of such facilities and those involved in consumer protection regarding the investment in these types of facilities is that our laws need to be more stringent; that all facilities identified as "continuing care retirement communities" should be made aware of the statutes which do apply to them and any such contracts reflective of whatever guidelines are statutorially applicable. The overall goal of the study and those concerned with this issue is to provide protective guidelines for both the developer and the consumer--guidelines not so stringent as to discourage the development of the concept, but those that would provide adequate protection for the consumer while encouraging the growth of the industry.

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Sub-Committee Report on Teen Pregnancy

INTERIM CHARGE: To study the problems of preventing unwanted teenage pregnancy, preventing poor parenting by teenagers, and preventing unemployment and poverty in teen-headed families.

Members of the sub-committee were Representatives Anne Cooper and Ron Wilson. Representative Lena Guerrero chaired the sub-committee.

PREGNANCY INCIDENCE AMONG ADOLESCENTS

The issue of teenage pregnancy has long been with us. Today, however, the problem has reached epidemic proportions. The United States has the highest teenage pregnancy rate of all industrialized nations. Each year, nearly 1.1 million young women become pregnant. If current trends continue, it is estimated that 40% of today's 14 year old women will be pregnant before the age of 19.

Texas ranks third in the United States in the number of babies born to the adolescents. Nationally, Texas is ranked second in the number of pregnancies to teens. The majority of teen mothers in Texas are not married.

Current statistics indicate that over half of 15-16 year old mothers, are recorded as unmarried. Among young mothers between the ages of 17-18 over a third were unmarried. In 1985, more than 18,600 babies were born to unmarried Texas teenagers.

These statistics indicate a serious problem in Texas. In 1985, 47,004 young women 19 years of age and under gave birth. Of this group, 1,079 were 14 years of age or younger. According to the Department of Health, the overall birth rate to teens has decreased except for young mothers fourteen and under. In 1981 Texas led the nation in the number of births to women under the age of 14 and younger.

In Texas little is known about the number of pregnancies in relationship to sexually active teens. Information on the number of miscarriages and abortions experienced by the adolescent population is not available.

Multiple pregnancies among teens in Texas are numerous according to the Texas Department of Health. In 1985, of the 47,004 teenagers giving birth statewide, 9,849 were second time births to teens. Teen mothers having a third child numbered 1,970. The combined fourth and fifth time births to teen mothers totaled 327 babies born in 1985. It is statistically projected that of the first time teenagers giving birth, 30% of them have a subsequent pregnancy within a two year period.

The alarming crisis lies in the number of babies born to the 14 and under age group. Statistics from the Texas Department of Health indicate an increase of 46% in the number of births for 13 year old adolescents between 1970 and 1984. A 9% increase in the number of births to 14 year old women has been recorded. Overall, the number of adolescent births has

increased regardless of ethnicity. However, the Hispanic population appears to be at greater risk due to a higher fertility rate.

In 1980 fertility for Hispanic women aged 15-44 was 95.4 per 1,000 women, 53% higher than the rate for non-minority women (62.4/1,000) and 5 percent above the rate for black women (90.9/1,000). In 1984 Hispanic teens surpassed the fertility rate of non-minority adolescents. Current projections include an increase in adolescent pregnancies by the Hispanic population. Duvall and Jim Hogg counties appear in the top 10 list by county in the incidence of birth rate. These counties are heavily populated by Hispanics.

Historically, the problem of teen pregnancy has been more profound in the Black population. Nationally, half of all black teenage girls become pregnant. In Texas, Black teens continue to struggle with the teen parent problem that severely limits and restricts their future. Teen parenthood contributes to the high rate of drop outs in school and high unemployment rates for black teens. Although Black teens have had high pregnancy rates, current statistics indicates a steady decrease in the fertility rate of black teens.

PREVIOUS EFFORTS To ADDRESS THE PROBLEM

Teen pregnancy first received the legislature's attention in 1982. Legislative studies have documented the state's grave problem. However, legislative measures have not been successful in establishing a state policy that addresses the adolescent pregnancy crisis facing the state.

During the 68th legislature, a Select Committee on Teenage Pregnancy was created to study the issue. Former State Representative Mary Polk of El Paso chaired the committee that rendered ten recommendations. Of Ms. Polk's recommendations, four were not implemented. Recommendations not implemented include:

1. The development of a central office

   within a state agency to handle adolescent pregnancy,

2. The establishmentof a comprehensive family life curriculum

   within the public education system,

3. The creation of a teen hotline and

4. Allowance of teen parents to remain under the auspices

   of special education until they complete high school.

Representative Wilhelmina Delco of Austin has in past legislative sessions introduced legislation that addressed the adolescent issue in the educational system. Attempts have been made to amend the educational code to allow the instruction of parenting training. No such legislative measures have been adopted.

The review of programs and state agencies providing services to teen parents reveals that most programs acknowledge prevention as the key in reducing the number of unplanned pregnancies by teenagers. However, most community based programs available in Texas today focus on meeting the needs of teen parenthood. The majority of the programs available in Texas place little emphasis on prevention due to the great demand for services by young parents. These services include access to social services, transportation, day care, and a host of parenting skill development programs. Most importantly, the continuation of secondary education and/ or job training has become a major concern of community based programs.

Community based programs located in major areas of the state have developed a variety of programs that attempt to address the prevention of teen pregnancy. Project Redirection in El Paso is a coordinated, comprehensive services project for pregnant and parenting teens developed and administered by the EL Paso YWCA. The YWCA has successfully joined with 15 entities including public agencies, service providers, and nine school districts to serve pregnant and parenting teens throughout El Paso County. Six case managers have responsibility for one of six designated geograhical areas each. The program also recruits community mentors to provide support and assistance to the teens. To further support those teen parents who are in school and to encourage them to stay in school, school liasons have been established in the two largest school districts.

Project Team in Houston is a coordinated, comprehensive services project for pregnant and parenting teens. Developed and managed by the Urban Affairs Corporation (UAC), the project is located in the Fifth Ward and provides services to teens in the surrounding area. The project is based in an alternative school where UAC operates a health clinic and day care center. All clients are required to continue their education until they have received their high school diploma or GED.

A Teen Parent Initiative Interagency Council was formed in 1985 to address the void for a community focused effort to serve pregnant and parenting teens and teens at risk. This initiative resulted from former Representative Polk's study.

The interagency council, made up of representatives from the Texas Department of Health, Texas Department of Community Affairs, the Texas Education Agency, the Texas Department of Mental Health and Mental Retardation, the Department of Human Resources Texas Youth Commission, and the Texas Health and Human Services Coordinating Council. This informal body has met regularly to discuss the development of a statewide policy on the war against unplanned teenage parenthood. This body does not have a legal base thus, their ability to develop and execute statewide policy is impaired.

Out of concern over the high dropout rate and the increasing number of teen pregnancies and teen parents in the public school system throughout Texas, the State Board of Education in July 1986 called for a plan of action from the Texas Education Agency (TEA). The Board directed TEA to emphasize prevention of school age pregnancy through the essential elements in social studies, health, physical education, science, and vocational education that focuses on personal decision making and responsibil-

ity. TEA has been instructed to collaborate with organizations and agencies in the identification of high-risk students. TEA has also been directed to serve as a clearinghouse for districts to disseminate information about community resources. TEA will develop and disseminate a K-12 technical assistance publication focusing on the teaching of self-responsibility and decision making in the prevention of school age pregnancy. The Board has delegated responsibility to the education agency for the provision of technical assistance to local education agencies in the development and implementation of resources for those essential elements addressed above. As a launching point in the implementation of the teenage pregnancy prevention program, "Education for Self-Responsibility", TEA will conduct a statewide conference in February 1987.

Despite the efforts cited, teen parenthood and the social problems associated with it, have not been successfully reduced. Statistics cited earlier indicate the incidence of unplanned pregnancies increasing for those females in the younger age groups, 14 and under.

OTHER STATE'S EFFORTS

In this decade, other states have tackled this ubiquitous problem,with differing approaches.

Wisconsin took bold steps during their 1985 legislative session and provided a package that included funding for sex education in public schools, repealed restrictions on the sale of non-prescription contraceptives and provided $1 million for counseling pregnant adolescents. The package also uniquely makes the grandparents of babies born to teenagers legally responsible for the newborn's financial support.

New York in 1985 enacted a comprehensive "Teenage Services Act" which establishes a case management system to assist pregnant and parenting teens receiving public assistance.

In Illinois, "Parents Too Soon" was instituted as a cooperative effort of 10 state agencies to reduce the teen pregnancy rate.

School-base health clinics, situated in or near public high schools have been sanctioned in at least 11 states. First started in Minnesota, the clinics demonstrate a 50% decrease in teenage child bearing and a decline in the drop-out rates from 45% to 10% over a eight-year period at the schools with health clinics.

MODEL LEGISLATION, STATE OF WISCONSIN

While 16 states have created task forces to evaluate the teen pregnancy issue, or passed legislation relating to teenage parenthood, only Wisconsin has passed comprehensive legislation dealing with the problem of unplanned teenage pregnancy.

The Wisconsin Legislature in 1985 passed the "Abortion Prevention and Family Responsibility Act of 1985". This act resulted from the recommendations of the Council's Special Committee on Pregnancy options. The 1985

Wisconsin Act 56, as it is commonly referred to, encompassed ten provisions that were enacted into law.

Provisions in the act related to : Adolescent Pregnancy Prevention and Services Board, - A board was named and attached to a major social service agency for administrative purposes, and will review grant applications and awards for pregnancy prevention programs or pregnancy services.

Human Growth and Development Instruction - Require each school board to establish a local advisory committee that includes parental involvement. It requires the development of a human growth and development curriculum and review of it at least every three years. The Human Growth and Development program includes instruction in self-esteem, responsible decision making and personal responsibility; interpersonal relationships; postponement of sexual activity; family life and skills required for parenting, human sexuality, reproduction, contraception, adoption, male responsibility; and sex stereotypes and protective behavior.

School age parents program - Requires the program to include education on skills required of parents; family planning, including natural family planning; and information on adoption. Requires coordination of the program with existing vocational and job training programs.

Adoption Center - Establishes a state center to provide information and referral services on adoption. Services included are training of persons who provide counseling to adolescents, operation of a toll-free telephone number, distribution of pamphlets and a media campaign.

Grandparent liability - Requires parents of a minor child to support that child's children, until the minor become an adult. Requirement sunsets after December 31, 1989. A report to the Legislature on the effects of these requirements must be received before January 1, 1989.

Insurance Coverage of Maternity Expenses - Requires insurance policies to cover maternity benefits to provide for all persons covered under the policy.

Abortion and Informed Consent - Requires informed consent of a woman prior to any abortion. A woman must receive information on medical condition relative to her pregnancy; contraceptive and adoption services information; and medical matters regarding abortions. The provision requires a written policy on parental notification of minors seeking an abortion from hospitals or clinics. The policy requires that minors be encouraged to consult parents or guardians or other appropriate person on the abortion unless they have a valid reason not to do so. It requires a minor to be informed of county social services person to assist in notifying parent or guardian. Unless written consent of a minor is given, hospitals or clinics may not notify a parent or guardian concerning an abortion.

Criminal Abortion Law - Defines "viability" to mean "that stage of fetal development when, in the medical judgment of the attending physician, based on the particular facts of the case, there is reasonable likelihood of sustained survival of the fetus outside the womb, with or without arti-

ficial support". The law penalizes person's performing an abortion after viability of the fetus, unless necessary for the life of health of the mother. Requires post viability abortions to be performed in a hospital or on an in patient basis. Requires that abortions be performed by physicians only.

Non-prescription contraceptive - Repeals current restrictions on advertising, displaying and selling non-prescription contraceptives except that the restrictions on sale of contraceptives in vending machines is retained.

PROBLEMS ASSOCIATED WITH TEENAGE PARENTHOOD

Teenage parenthood encompasses the scope of family concerns today. Issues associated with unplanned child bearing by adolescents are many: health, infant mortality, poverty, child support, child abuse and neglect, foster parenting, education, child care, and job training.

Testimony from social workers, program administrators and public policy analysts revealed that the most pressing issue is economic problems for young women and their offspring. Teen mothers and their children are far more likely to be poor, single-parent families. A representative of the Texas Department of Human Services (DHS) testifed that teen mothers are only half as likely to graduate from high school, and their income is about one-half that of those who wait until they are in their twenties to have their first child. In 1985, DHS estimated an average of 8,800 teen mothers received Aid to Families with Dependent Children (AFDC) each month. Some recipients were as young as 11 years of age. They had 20,000 children among them.

Teen parents are prone to school failure and subsequent employment difficulties. Eight out of every ten pregnant teenagers will not complete high school. The Texas Family Planning Association estimates that 40% of teen mothers and 33% of teen fathers with children under the age of six have not finished high school.

Health concerns include low birth rates, poor nutrition, and lack of prenatal care. Low birth weight and infant mortality rates are greater for babies born to teen mothers. Testimony revealed that teen mothers are at greater risk for maternal death, birth complications, premature babies and lower IQ's for their children.

"Children having children" is placing tremendous stress on families today, both financially and emotionally. The Wisconsin law requiring the financial support from grandparents to babies born of their minor children has added a financial burden to the family unit. This action has placed greater responsibility on the adult members.

Nationally, 96% of unmarried mothers keep their babies. The implications of inadequate parenting places the responsibility on other members of the household. The Texas Association Concerned with School Age Parenthood states that adolescent mothers attempt suicide seven times more often than their peers.

Echoed among the testimony received, particularly from teen mothers was the role of the adolescent male. Dr. Peggy Smith, Baylor College of Medicine, testified that the role of the male is not to be ignored, for it is primarily the male who is the precipitating force of sexual exposure, expericence, and even pregnancy. The omission of the male's involvement in the the pregnancy parenting crisis, serves only to perpetuate the myth that males do not have to be financially responsible for children they help to conceive. Thus, it becomes a child support issue faced not only by families, but also by the state. Lack of emphasis on the male's involvement, his responsibilities, and the consequences of his behavior were identified as problems associated with teenage parenthood.

Teens testifying indicated a deficit in their ego development and self-esteem. Teens consistently stated they were seeking out nurturance and love from the boys who fathered their children and later from the babies they gave birth to. Teen mothers believed their emotional needs would be met by their newborns. Instead, they were overwhelmed by the demands brought by parenting. Testimony from teen parents revealed they were unaware and unprepared for the responsibilities of parenthood. One teen mother said she did not know how to spend her money, or how to buy what her baby needed. What she testifyied to was her inability to prioritize her child's needs and her needs or wants.

Another problem associated with the teen pregnancy issue is the message communicated by the media at large. Susan Pokorny, M.D. testified to the number of sexual intercourse messages conveyed by the media during prime time television. According to Dr.Pokorny, on an annual average, there are 9,000 messages on T.V. that communicate the message that sexual intercourse can occur without the consequences of pregnancy. Dr.Pokorny stated " given the enormous number of times that children are bombarded with the message from television, movies, videos, rock-music, that not only are people engaging in sexual intercourse, but that there are no significant consequences such as pregnancy, should it be of any wonder that many young teenagers engage in sexual relationships and truly think they cannot get pregnant?"

COSTS ASSOCIATED WITH TEEN PARENTHOOD.

The issue of children bearing children translates into an exponential public cost. IN 1975, the federal and state governments collectively spent $8.6 billion on AFDC, Food Stamps, cash benefits, and Medicaid for teens who were pregnant or gave birth. The average first baby born to a teenage mother in 1985 will cost the state taxpayer $15,620 by the time that baby becomes an adult. Babies born to mother under 14 will cost $18,089; babies born to mothers aged 15 to 17 will cost $17,203; babies born to older teens will cost $14,481. If a similar infant is born after the parent was a teenager, taxpayer savings would be $6,248 per year. These figures included AFDC, Food Stamps, Medicaid, public housing and social services costs. Not all children born to teen mothers cost the state money. There are some teen mothers and their children who are supported by their parents.

Last year, the Texas Department of Human Resources paid out approximately $11.7 million in Medicaid benefits for maternity and obstetrical care to more than 7,000 teenage mothers. The Texas Department of Human Services estimates that it costs Texas approximately $6,000 to provide AFDC, Food Stamps and Medicaid benefits to a mother and child in the first year alone when a teenage mother goes on AFDC due to an out-of wedlock-birth. In fiscal year 1985, Texas Department of Human Resources paid out over $15 million in AFDC payments to teenage mothers.

SUB-COMMITTEE RECOMMENDATIONS

This Sub-Committee respecfully recommends the adoption of a comprehensive public policy on teen pregnancy that includes the following:

I. Central State Coordination and Responsibility

A. State Policy -- The State of Texas recognizes the crisis of unplanned teenage pregnancy as a major concern for the State. It is the policy of the State of Texas to prevent to the maximum extent possible the incidence of unplanned teen pregnancy and to provide adequate services to teens who are pregnant and unmarried, who become parents. The Texas Legislature directs that all state agencies assume appropriate responsibility for resolving this problem.

B. State Agency Coordination and Responsibility -- The Texas Health and Human Services Coordinating Council (HHSCC) is designated the central state agency responsible for overall coordination of teen pregnancy programs for the State of Texas. In this capacity, HHSCC will perform the following activities and responsibilities:

1. Establish and chair an Inter-Agency Teen Pregnancy Committee, composed of the administrative heads of the Texas Department of Human Services, Texas Department of Health, Texas Education Agency, Texas Youth Council, Texas Department of Community Affairs, Department of Mental Health and Retardation, and others as appropriate.

2. Coordinate programs aimed at prevention of teenage pregnancy and services to pregnant and parenting teens among various state agencies, including recommendations for new agency initiatives and reforms to prevent duplication of services.

3. Empanel a Community Advisory Committee of not more than 15 persons drawn from the private and non-profit sector to advise the HHSCC and the Inter-agency Teen Pregnancy Committee on teen pregnancy issues. Membership should include representation from local community teen pregnancy projects and all geographic areas of the state.

4. HHSCC shall serve as the statewide information clearinghouse on Teen Pregnancy and make this information on Teen Pregnancy available to the Legislature, to other state agencies and to

private entities involed with this problem. To the extent possible, HHSCC shall also provide technical assistance to local teen pregnancy problem and about the various programs addressing the issue.

5. Maintain an ongoing data-base and statistics on teen pregnancy in the state. This effort should insure that all agencies are utilizing the same types of information and data so that evaluation and comparison are facilitated.

6. Provide onging analysis and evaluation of the data collected and studies done on the issue of teen pregnacy. This analysis shall be readily available to the agencies, the Legislature and to the general public.

7. Report to the 71st Legislature and subsequent sessions on the status of teen pregnancy programs in the state and on the accomplishment of the above cited responsibilities.

Alternative to 2. above

8. 2. State Agency Coordination and Responsibilitv - There is created the Texas Inter-agency Coordination Committee on Teen Pregnancy. This Committee shall be composed of the agency heads or their designees from the following state agencies: Texas Department of Human Services... This Committee is designated as the central agency responsible for overall coordination and planning of Teen Pregnancy programs. For administration and support the Committee is attached to the Texas Department of ... The Committee will perform the following activities and responsibilities:

II. ONGOING PROGRAMS

A. Programs of Prevention

1. Family Planning Services and Information
Confidential family planning services and information should be expanded to reach additional teenagers.

Special funding should be appropriated throughout the Texas Department of Human Services or the Texas Department of Health to family planning providers specifically earmarked for targeting teen pregnancy prevention services. (1) These services should include information, counseling, and contraceptive education. (2) Program services should provide outreach in the community to educate adolescents on available services and on accessing these services. (3) Encourage and train parents to discuss family life issues and promote parent-teen communication about family responsibilities including biological behavior via the utilization of existing community based, non-profit groups within communities.

2. School Based Clinics

Funding for pilot School-Based Adolescent Health Care Clinics should be appropriated. Having had a very significant and positive effect on the decline of pregnancy rates in several states, these comprehensive on-campus health care facilties for teenagers should be funded. The success of these clinics has also had a positive effect in the decline of the drop out rate among youth.

Grants for school based clinics should be given in communities where "matching" monies have been raised or appropriated locally, or where there is evidence of local support.

B. Programs of Intervention

1. Teen Parent Programs.

There should be continued support and expansion of teen parent programs within Texas communities. Components of these programs should include:

a. Keeping the teen parent in school

b. Helping insure employment

c. Insuring teen parents have access to daycare, both private and school based

d. Helping teens secure financial assistance

e. Insuring the teen parent has access to family planning services and information in order to prevent subsequent unintended pregnancy

f. Providing an advocacy program so that teen parents have positive role models and worthy goals.

g. Transportation

h. Parenting and life skills training

2. Prenatal Care and Hospitalization

Funding should be made available to insure pregnant teens receive early and continued prenatal care.

Expansion of hospitalization care should be considered.

A program of outreach and communications should be developed to insure communities know about the services, and teens can access them.

3. General

All programs for teens, preventive and interventive, should provide services at times which are convenient for teens.

Networks of services should be developed in all communities.

Resources directories for teens should be developed.

III. COMPREHENSIVE FAMILY LIFE EDUCATION -

Implementation of an effective family life education curriculum within the public schools (k-12).

Direct the Texas Education Agency to develop and implement a family life education curriculum aimed at the prevention of unplanned teen pregnancies. The curriculum should include the following goals: to develop an acumen toward sexuality, enhance self-esteem, develop an ability to relate to and respect the rights of others, to protect one's rights, and provide a realistic understanding of marriage and family life issues. Family life education will include these objectives:

A. Instruction to develop an understanding of the physical, mental, emotional, social, economic, and psychological aspects of personal relationships.

B. Instruction on the physiological, psychological and cultural foundations of human development, human sexuality and reproduction at various stages of growth.

C. Instruction on the development of responsible decision making, acceptance of consequences for personal choices, and self-esteem and personal worth development.

D. Inclusion of local advisory committee for input on the development of the family life education program within the local school districts.

IV. PUBLIC AWARENESS CAMPAIGN -

The development and initiation of a public awareness campaign combined with the resources to the private sector should be part of the commitment to combat the teen pregnancy epidemic. Two campaigns should be instituted aim at the following:

A. A public awareness campaign using the media and informing the general public of the problem regarding teenage pregnancy and parenting in Texas.

B. A teen awareness campaign using the media, especially rock radio stations, informing teens of the consequences of teen

parenthood and the availability of confidential family planning services within their communities.

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INTERIM CHARGE: To study the advantages and disadvantages of the preferred provider insurance plan, with particular emphasis on consideration of quality of services, access to services, cost of care rendered, the effect on existing physician-patient relationships, and a proposed legislative/regulatory structure for such medical care delivery and financing arrangements; in conjunction with Insurance and Public Health Committees.

On June 4, 1986, the State Board of Insurance adopted rules for regulating preferred provider arrangements. The adoption of these rules appears to obviate the need for other remedies through the legislative process.

A more detailed background on this issue and an analysis of the rules that were adopted by the State Board of Insurance can be found in the interim report on this topic by the House Committee on Insurance. This Committee concurs with those findings.

INTERIM CHARGE: To study the utilization of and potential for further development of privatization of care for the mentally ill and mentally retarded in the State, in conjunction with Appropriations and Law Enforcement Committees.

There has been an increasing interest in the issue of privatization. Not only have House Committees been asked to study how privatization of state services could provide both improved quality and lower cost, but the Sunset Advisory Commission and the Texas Commission on Economy and Efficiency in State Government have been closely studying the issue as well. In fact, these two Commissions held a joint meeting on January 22, 1986, to extensively review privatization.

In order to study the potential for privatization in greater depth, the Commission on Economy and Efficiency in State Government contracted with the Lyndon Baines Johnson School of Public Affairs at the University of Texas at Austin to conduct research and prepare reports on the issue. The research was assigned to the Policy Research Class of the LBJ School.

The area of privatization that is of particular interest to this Committee is in services for mental health and mental retardation. Two separate teams of the Policy Research Class consisting of three members each worked on this issue, one on privatization of mental health programs and the other on mental retardation programs. Each team was able to study the potential for privatization in their respective area in great detail, including on-site visits to other states that have had varying degrees of experience and success with privatization.

Because of the resources that the LBJ School was able to use to study this issue, we have not attempted to duplicate this effort with the more limited resources at the Committee's disposal. We have, however, monitored the progress of the LBJ School study and reviewed the drafts that were initially presented to the Commission on Economy and Efficiency in State Government on April 16, 1986.

In general, the study groups found that the potential for privatization is greater for mental retardation services than for mental health services. For the latter, there are several obstacles to private management of long-term mental health services at state hospitals although there may be some potential for short-term services.

For mental retardation services, the research team found that the trend toward community-based services presents an opportunity for expanding contracts for community-based mental retardation programs and services.

The final reports and recommendations should be available from the Texas Commission on Economy and Efficiency in State Government prior to the convening of the Seventieth Legislature.

INTERIM CHARGE: To study the impact on Medicare-Medicaid and associated state health and welfare costs of the elimination of the certificate of need process in Texas.

Introduction

During the Sixty-ninth Legislative Session, The Texas Health Facilities Commission, which was the state agency responsible for the certificate of need process, was up for sunset review. Despite a recommendation from the Sunset Commission that the Health Facilities Commission be continued with certain modifications, the Legislature chose to abolish the agency by allowing enabling legislation to expire on September 1, 1985. With the end of the Texas Health Facilities Commission came the end of the certificate of need process. Although the decision to end this process was based primarily on criteria unrelated to the Medicare-Medicaid programs and other state health and welfare costs, it was apparent that this decision could have an impact on these costs that would be in conflict with other state policy goals and objectives that had previously been clearly articulated by the Legislature. The purpose of this study is to determine what this impact might be and to review the steps that have been taken to mitigate this impact and the extent that this has been accomplished without disturbing the legislative intent in abolishing the Health Facilities Commission.

Certificate of Need

The certificate of need concept was introduced with the National Health Planning Resources Development Act of 1974 (P.L. 93-641), which required states to establish a state health planning and development agency, a state health planning advisory council, regional health planning agencies, and a certificate of need program. The purpose of a certificate of need program was to determine whether or not a need for a health care facility exists prior to its development. The intent was to control the escalating cost of health care by assuring that unneeded facilities with empty beds would not be forced to recover their investments through higher costs. In compliance with the federal law the Sixty-fourth Legislature enacted the Texas Health Planning and Development Act, which created the Texas Health Facilities Commission as an independent agency responsible for the certificate of need program. The Commission was established in 1975, and during the ten years of its existence both the certificate of need process and the agency itself came under increasing criticism.

The thrust of this criticism from some physicians, hospital groups, and legislators was summarized by a House Study Group Report issued at the beginning of the Sixty-ninth session:

- -- THFC review of capitol spending interfers needlessly with the free play of market forces. Health care is a market like any other and should be regulated only by the dynamics of competition in the marketplace, without government interference.
- -- Certificate-of-need review does not get at the underlying conditions such as the overuse of health services that have been pushing up health-care costs. In fact, it makes the problem worse.

-- It takes too long to get a certificate of need, and the THFC's regulations burden health care providers with minutiae.
-- The THFC shows favoritism toward some health-care providers and their law firms.[1]

The legislative debate over the certificate of need process and the Texas Health Facilities Commission was often heated and the issue was a controversial one. In the end, however, the Commission was abolished.

Cost Containment and Long-Term Care for the Elderly: Other Priorities

Recent years have also witnessed the development of other state policies by the Legislature to contain the cost to the state of publicly financed health care, particularly in the Medicaid program which is financed by an approximate 50-50 state-federal match. A significant portion of the state Medicaid costs is in nursing home payments. In fiscal year 1986, $457,920,386 is appropriated for nursing home vendor payments. Undoubtedly these costs would have been higher had not previously policies been established during the past several years.

Perhaps most significant was the work of the Joint Committee on Long-Term Care Alternatives, which was created by the Sixty-fifth Legislature to study both quality and costs related to care for the elderly. In its report of January 1979, the Joint Committee found that institutional care for the elderly was often not needed if other community based and home based programs were made available.[2] As these non-institutional programs were less costly and provided a higher quality of life, a policy was adopted and implemented by successive Legislatures to control expansion of nursing home placements and increase home and community care.

During the 1979 regular session of the Legislature several measures were passed that reflected the recommendations of the Joint Committee. Adult day care (S.B. 828) and respite care (S.B. 829) programs were initiated. The Legislature also directed the Department of Human Resources to phase out the ICF II level of nursing home care. ICF II patients were those with the lowest level of medical need who could be served through alternative programs.

In 1983, the Legislature passed S.B. 711 which created the Long-Term Care Coordinating Council for the Elderly. This Council, jointly chaired by the Governor, Lieutenant Governor, and the Speaker of the House, continues to pursue the objectives initiated by the Joint Committee. Among the specific objectives adopted by the Council is to, "Assure the least restrictive service option is available for the individual." [3]

In order for this policy to be successful it was necessary to limit the expansion of the number of nursing home beds, particularly those that could be used by Medicaid patients. This limitation was necessary because of the reimbursement methods states are forced to use under the Medicaid program and the effect such a method has on overall costs and utilization of the program.

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[1] House Study Group, Special Legislative Report, The State and Health-Care Cost Containment, January 24, 1985, No. 108, p. 1.

[2] Joint Committee on Long-Term Care Alternatives, Final Report, January 1979.

[3] Long-Term Care Coordinating Council for the Elderly, Texas Long-Term Care Plan for the Elderly, 1984-1986, December 1984, p. 24.

Medicaid Reimbursement and Nursing Homes

The Medicaid program is a cost-related system. Under federal regulations we are required to reimburse providers for all expenses incurred in providing services plus a reasonable profit. These costs are broken down into categories such as patient care, facility, dietary services, and administration. Directly related to what these expenses will be on a per patient basis is the occupancy rate. This is particularly critical in the nursing home industry. Obviously a nursing home that enjoys a consistently high occupancy rate will operate more cost-effectively than one that does not. Some nursing home costs are less affected by this than others. Dietary costs, for example, are more related to the number of patients and decrease only slightly on a per patient basis with an increased occupancy rate. But recovering the costs for the facility is dramatically affected by occupancy rates. Such costs are relatively fixed and remain the same regardless of the number of patients in the nursing home. If there are few patients relative to the number of beds then these costs must be much higher per patient than if there are more patients and the costs can be spread out more evenly. Occupancy rates do then affect the rate the state is required to set as reimbursement. In one example, per patient per day cost in a nursing home with a 40% occupancy rate that would be around $44.00 would drop to about $26.00 in a facility with an 80% occupancy rate.

Since the State of Texas through the Medicaid program buys about 70% of the nursing home care in the state and half of those payments are state dollars, it is clearly sound state fiscal policy to prevent overbedding in the nursing home industry that would result in lower occupancy rates and correspondingly higher reimbursement rates.

It is, of course, not appropriate state policy to so restrict the number of nursing home beds that can be utilized under the Medicaid program to the extent that eligible patients in need of nursing home placement would be denied access to such care. If occupancy rates approached 100% access might become a problem. Currently state-wide occupancy rates in nursing homes are about 80%, a level which seems to both contain costs and provide access to care for most Medicaid eligible patients. Problems with a minority of patients who may require a higher level of care than average and the lack of access to skilled beds is not related to occupancy rates. That issue is discussed in our report on post-hospital care for the elderly.

A second issue that is related to occupancy rates in nursing homes is quality of care. Clearly it is also a goal of the State of Texas to assure that standards of quality are maintained in the care that is received in nursing homes. To that end we have set standards that must be met and we have an inspection program administered by the Department of Health. We find that quality of care is not only related to standards and enforcement but is also directly related to occupancy rates. Nursing homes with lower occupancy rates have significantly more problems in meeting standards of quality than do homes with higher occupancy rates. It should not be surprising that nursing homes that enjoy the higher cost-efficiency of a high occupancy rate will be able to consistently offer better care to its patients than a home operating inefficiently because of a lower occupancy rate. The statistics bear this out. Of those nursing homes with occupancy rates between 70% and 79%, 25 of 168 or 14.9%, had contracts terminated because of contract violations and poor quality of care. Facilities with occupancy rates between 80% and 89% had problems in 21 of 215 facilities or 9.8% that had contracts terminated. For those nursing homes with an occupancy rate of 90% or more, only 4.2% had contracts terminated or 17 of 402 facilities.

Increased Utilization and State Policy

If the number of Medicaid reimbursed nursing home beds in Texas were allowed to increase then it could also be expected that this would lead to increased utilization. Over twenty-five years ago an influential study was published which formulated Roemer's Law, named after one of the authors of the study. This law in effect states that as empty beds increase utilization will increase if reimbursement is guaranteed. This study was aimed primarily at hospital utilization and payment by the private insurance industry, but subsequent studies and experience have shown that the law is no less true for nursing home utilization and assured reimbursement by the Medicaid program.[4] An unrestricted growth in the number of nursing home beds would then result in more individuals being placed in nursing homes despite their lack of need for this level of 24-hour institutional care. Such a development would run counter to the state policy that has been pursued for the eight years since the recommendations of the Joint Committee on Long-Term Care Alternatives began to be implemented.

We conclude that the elimination of the certificate of need process will have a negative impact on state health and welfare costs and will also have a negative impact on other state policy objectives. To summarize the state policies that can be affected:

(1) Controlling Medicaid costs to the state in general, and in particular to the Medicaid nursing home program;
(2) Providing less restrictive alternatives for long-term care through primary home care and other home and community based programs;
(3) Assuring the higher quality of nursing home care that higher occupancy rates help to promote.

Certificate of Need Predates Current Cost Containment Policies

This is not to say that these concerns regarding the impact of the elimination of the certificate of need process will have on these objectives argue for a return to such a process. The Texas Health Facilities Commission was created and the certificate of need process was begun for much broader public policy reasons than the need to control the cost of Medicaid reimbursement for nursing home care. The process began even before the development of a strategy to utilize less costly and less restrictive types of care for the elderly.

By the same token, the Texas Health Facilities Commission was abolished and the certificate of need process was eliminated for much broader public policy reasons than those associated with providing the most appropriate level of care for the elderly.

The certificate of need process was abandoned for many reasons, but nowhere in the debate do we find that those reasons included the desire to abandon a policy to provide care for the elderly in the least restrictive environment or to give up on a policy to contain Medicaid expenditures and maintain quality of care in nursing homes.

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[4] Roemer and Shain, Hospital Utilization Under Insurance (Chicago: American Hospital Association, 1959).

As long-term care planning goals were being developed in the early 1980s the certificate of need process was already in place and could be relied upon to help in achieving these goals. That process was probably more than needed but since it was already there having been created for other reasons, it made sense to take advantage of it. But as a tool to assist in achieving long-term care goals the certificate of need process was a bulldozer when a shovel would have been more appropriate. The broad goals of the certificate of need process, the expensive bureaucratic mechanism that it required, the costs it added to the construction of needed hospitals and other health-care facilities were aspects of a program unneeded in achieving the more limited goals of long-term care planning.

But with the bulldozer that was the Health Facilities Commission gone we find that some finer tool is still required to accomplish our more limited objectives. Eliminating certificate of need has left us with the need for an alternative and less intrusive way to achieve similar results in our long-term care policy, but without circumventing our other intentions in the sunsetting of the Health Facilities Commission.

Effect of Elimination of Certificate of Need on Other Policies

It is clearly important to assess the extent the end of the certificate of need process will negatively affect long-term care planning and controlling Medicaid costs in lieu of any alternate controlling mechanism. Such an assessment can be based on past experience when there were no controls and no long-term care planning, and on projections on costs in the future.

We find that previous efforts to control health care costs had been situated in the Office of Health Planning in the Governor's Office. The Governor eliminated this office in mid 1973 which ended controls on building new nursing homes in Texas. Almost immediately the Medicaid nursing home program experienced substantial growth. Thirty new facilities were certified and 10,000 additional beds were added to both new and existing nursing homes. The occupancy rate statewide for nursing home beds decreased from 86% to 80%. After two years of virtually no controls the Health Facilities Commission was created. The stability the Commission brought to the nursing home industry helped long-range planning considerably when alternative policies for care for the elderly were initiated in 1979 and cost containment in Medicaid became critical. In 1985, the use of primary home care programs instead of nursing home care will save the State of Texas about $128.6 million, a savings that could not have been achieved in the absence of controls on nursing home beds.

Estimated Future Cost Impacts

An analysis of the impact on future state Medicaid costs that would result from a lack of controls on nursing home beds was prepared by the Department of Human Services. In that analysis, using the most conservative estimate of a 10% increase in beds over a three year period with a 50% occupancy rate of the new beds and 70% of those patients being Medicaid eligible, additional costs would be $11.2 million for FY 1986, $22.6 million for FY 1987, and increase to $42.9 million by FY 1991.

At a higher and less conservative growth rate projection of 20%, increased additional costs could reach $27.3 million for FY 1986, $54.6 million for FY 1987, and reach $100.9 million by FY 1991.

If a higher occupancy rate for the new beds is assumed, cost increases would be even higher as clients increase in number. With the conservative 10% growth rate and an 83% occupancy rate, increases would be $18.7 million in FY 1986, $37.0 million in FY 1987, and up to $65.5 million in FY 1991.

At a 20% growth rate and an 83% occupancy rate, the added costs would be $45.3 million in FY 1986, $89.6 million in FY 1987, and $157.0 million in FY 1991.

It is important to remember that many of these new clients would be persons now served by Family Care and Primary Home Care. Currently as many as 5,300 Community Care for the Aged and Disabled Clients are medically eligible for Medicaid paid nursing home care. An increase in nursing home beds would shift many of these clients away from less restrictive and less costly community based programs.

One set of hard data that indicates such projections are realistic expectations is found in the number of applications for new facilities pending before the Texas Department of Health. As of December 1, 1985, TDH has pending-approval applications for 138 new facilities which would contain 12,405 new beds. There are also requests from existing facilities for additions which would contain another 1,745 beds. It seems certain that with the end of the certificate of need process and in lieu of any other control the nursing home industrywould rapidly become destabilized for the first time in over a decade. The consequences of this destabilization and the overbedding that would result are of extreme concern from both a long-term care planning perspective and from a cost-containment perspective.

Action Taken in Response to Change in Planning Environment

Faced with the potential impact on Medicaid costs, the long-range plan of providing alternatives to nursing home care, and the desire to manintain quality of care, the Department of Human Services felt that it was within their area of responsibility to seek alternate methods of controlling the number of Medicaid eligible nursing home beds. With the end of the certificate of need process some alternative would be necessary if other long-standing policy directives of the Legislature were to be continued. The dilemma the Department faced was to find an appropriate mechanism that would achieve state policy goals on the one hand while not reinstituting the certificate of need process. We believe that had the Board of the Department of Human Services failed to seek a solution to this dilemma they would have not met their responsibility as administrators of the state Medicaid program. However, because this was such a dilemma, involving two apparently contradictory legislative directives, it was not surprising that whatever action that was taken would involve controversy.

Additionally, it must be mentioned that there exists another and perhaps overriding policy consideration, that is, to control state spending across the board. That need has become paramount through 1986 as revenue estimates have declined and budgets have been trimmed. Funding levels for nursing home reimbursements were based on past assumptions on rates that would be set and numbers of patients. Those funding levels made no allowances for changes in those assumptions that would result from a destabilizing of the nursing home industry that an end of controls would bring. Funding levels therefore implied an expectation by the Legislature that reimbursement rates and occupancy rates would continued to be controlled. Had the Board of DHS taken no action to maintain the environment upon which funding levels were established it is certain that they would have been held accountable for cost overruns in the Medicaid nursing home program that would have inevitably have resulted in lieu of such action.

Medicaid Contract Morotorium

The action taken by the Department of Human Services was to impose a morotorium on Medicaid contracts. This action was in the form of an emergency rule originally applied to all Medicaid contracts with both hospitals and nursing homes and became effective on September 1, 1985, the date the Texas Health Facilities Commission expired.

The Board adopted the emergency rules at its July 11, 1985, meeting. Following the adoption of these emergency rules, the proposed morotorium was presented to the Department's Medical Care Advisory Committee and Aged and Disabled Advisory Committee and public comment was received.

At a Board meeting on November 21, 1985, the morotorium on hospital Medicaid contracts was lifted effective December 30. Study had indicated that because Medicaid reimbursements account for only a relatively small percentage (6%) of hospital beds, the effect of lifting the morotorium would be minimal. However, since Medicaid reimbursements account for the majority of licensed nursing home beds in Texas, it was decided that it would be necessary to continue the morotorium for nursing homes. A permanent rule was then proposed which included several important modifications primarily intended to assure an adequate supply of beds on a regional basis. The proposed permanent rule was published in the December 13, 1985, Texas Register.

At the January 30, 1986, meeting, the Board adopted a morotorium on Medicaid contracting for nursing home beds. The rules governing this morotorium were implemented on March 1, 1986.

At that same meeting an adjustment to the morotorium was proposed. This adjustment provides a mechanism for the lifting of the morotorium when occupancy rates in geographic catchment areas reach 90% and a procedure for the Department to contract for additional beds in that area. These adjustments appear reasonable and help to assure that a sufficient number of Medicaid contracted nursing home beds will be available for those who are both medically and financially eligible and for whom primary home care or other community or home based care would not be an appropriate alternative.

Conclusion

We find that overall the imposing of a morotorium on contracting for Medicaid beds with nursing homes was appropriate. Although there has been genuine concern expressed that a morotorium circumvents the intent of the Legislature when it abolished the Texas Health Facilities Commission, we find nothing in the morotorium that replaces the Commission or reinstitutes a certificate of need process, and no action by the Board of DHS ever seemed directed toward such ends.

For one thing the use of the morotorium was not without precedent as a tool to manage Medicaid costs. In the late 1970s community-based mental retardation facilities (ICF-MR) that had Medicaid contracts began to grow dramatically. In a little over a year and a half client population grew by 340% and expenditures increased by 550%. In attempting to control costs the Department imposed a morotorium on contracting that went into effect on July 13, 1981, and was continued until May 1, 1982, when another mechanism was instituted.

In assessing the nursing home morotorium it is perhaps as important to understand what it does not do as it is to understand what it does do. The morotorium and the rules by which it operates does not contain those elements of the certificate of need process which had been the most criticized. The

morotorium as finally adopted does not affect hospitals. It does not affect facility construction but only contracts with the Medicaid program. It does not require a costly and inefficient regulatory agency. It does not add to the cost of new facilities by establishing an expensive competitive selection process when new beds are needed. It does not prohibit anyone from building anything.

Of course placing a morotorium on Medicaid reimbursed beds may have the effect of limiting new construction in the nursing home industry since operators will not be able to assume that publically funded reimbursement will be guaranteed. Some will continue to argue that this is interfering with the free market system. But since this is an industry for which the State of Texas is currently providing 83% of the income and which we are required by federal regulations to use a cost-plus reimbursement system, we are hardly talking about free market conditions in the first place. It is doubtful whether the federal government would have moved to deregulate the airline industry had the government been purchasing a majority of the tickets, and knowing that with deregulation would come new planes and new routes that would be added irrespective of demand because the industry would know that the costs would be recouped through higher ticket prices that the government would still be required to purchase, and that new government-paid passengers would soon be flying who had previously been served by more appropriate and less expensive forms of transportation, and, finally, that the overall quality of services and safety would be impaired with declining cost-efficiency.

As the buyer of most nursing home care in the State we certainly have the obligation to be a smart buyer, to buy no more than we need, and not to pay rates that are inflated to cover the cost of empty beds. As the governing board of the single state agency responsible for the Medicaid program in Texas, and responsible for providing care for the elderly in the least restrictive and most cost-efficient method possible, the Board of the Department of Human Services has acted in keeping with those responsibilities.